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

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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

Natividad Medical Center

Health Care System Designation(DPH or DMPH)

DPH

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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.

Natividad Medical Center is an acute care hospital owned and operated by the County of Monterey and located in Salinas, California, the county seat. Monterey County is 120 miles south of San Francisco and 345 miles north of Los Angeles, bordered on the north by Santa Cruz County, the south by San Luis Obispo County, the west by the Pacific Ocean and the east by the Gabilan Mountain Range and San Benito County. Monterey County is the third largest agricultural county in California and agriculture supplies the majority of the jobs in the county.

The growing population of Monterey County demonstrates the existence of social and economic disparities which include:

- The Hispanic/Latino population comprises approximately 56% of the population of Monterey County.
- Thirty percent (30%) of Monterey County's residents had less than a 12th grade education as of 2012.
- Nearly 40% of Monterey County residents live at or below 200% of the federal poverty level.
- Nearly 25% of the Hispanic/Latino population lives below the federal poverty level compared to 8% of the white, non-Hispanic population.

Social and economic disparities also reflect health disparities that exist in Monterey County:

- Age-adjusted diabetes mortality rates significantly decreased from 1999 to 2010 for Black and Hispanic/Latino residents. Despite this, in 2008 – 2010 rates among Hispanic/Latino residents were significantly higher compared to White, non-Hispanic residents.
- In 2009, 45% of Hispanic/Latina women reported never having had a mammogram for breast cancer screening; the White, non-Hispanic percentage was 17%.
- In 2009 45% of Hispanic adults reported never having had a sigmoidoscopy for colorectal cancer screening; the White, non-Hispanic percentage was 19%.

Although Monterey County experienced significant improvements in its health status over the last decade, health challenges still exist:

- The leading cause of death in Monterey County is heart disease, the cause of 25% of all Monterey County mortalities in 2010.
- The percentage of adults who reported themselves as a current smoker from 2003 to 2012 was 11%. In 2012, there were three times as many male smokers compared to female smokers.
- All of Monterey County is designated as a primary care shortage area by the federal Health Resources and Services Administration. Most of the county is medically underserved for general medical, dental and mental health services.

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.

Monterey County is comprised of 12 incorporated cities, and is divided into the following regions: Monterey Peninsula (Monterey, Pacific Grove, Carmel-by-the-Sea, Carmel Valley, Seaside, Marina, Sand City, Del Rey Oaks and Pebble Beach); Big Sur; North County (Marina, Moss Landing, Prunedale and Castroville); and the Salinas Valley (Salinas, Soledad, Gonzales, Greenfield and King City). Monterey County has a population of 415,057 people with a growing Hispanic/Latino population of 56% in 2012.

Income. The per capita income in Monterey County is $24,048, the median income is $52,582 and 17% of the population lives in poverty. The median age in Monterey County is 32.9 and only 10.7% of the population is over the age of 65.

Race, Ethnicity and Language. The population of Monterey County is 56% Hispanic/Latino, any race, 32% White, non-Hispanic, 7% Asian/Pacific Islander, 3% Black, non-Hispanic, 1% Native American/Native Alaskan and 1% Multi-Race/Other. In Monterey County, 52.8% of residents reported speaking a language other than English at home.

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.

Natividad Medical Center (NMC) is a licensed, 172-bed acute care hospital and is a Level II Trauma Center. NMC operates with a medical staff of over 300 physicians, has several specialty clinics and two outpatient primary care clinics. The Monterey County Health Department operates several outpatient primary care clinics and outpatient Behavioral Health Services on the hospital campus, affiliated with NMC but operationally separate.

NMC is affiliated with the University of California, San Francisco (UCSF). Recognized as a model program, NMC's Family Medicine Residency Program is postgraduate training for physicians specializing in family medicine.

Natividad is governed by a Board of Trustees, under the guidance of the Monterey County Board of Supervisors. NMC has been providing essential services to the residents of Monterey County for over 129 years.

Highlights of Natividad

- Natividad delivers more than 2,500 newborns each year and is the county's only hospital to offer vaginal birth after cesarean section (VBAC) service.
- Natividad has more than 51,000 Emergency Department visits each year, one-third of which are children.
- Natividad has the Central Coast's only inpatient and outpatient acute rehabilitation program.
- Natividad has the county's only child sexual abuse clinic providing medical-forensic examinations.

For fiscal year 2016 year-to-date, NMC's payer mix is: 52.3% Medicaid, 19.1% Medicare, 20.8% Commercial Insurance, 5.7% Self-Pay and 2.1% Short Doyle. NMC has 32,559 acute inpatient discharges, 69,182 ambulatory care visits and NMC's average length of stay is 4.5 days. NMC's occupancy rate is 72.1% and staffed beds as a percentage of licensed beds is 80%.

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.

Natividad Medical Center (NMC) is assessing and developing a multi-year longitudinal care and community health redesign program as part of its population health management strategy. While this strategy is developed and in order to meet PRIME requirements, NMC has implemented a transitional data collection, reporting and monitoring process.

Data Collection

NMC performed a gap analysis to determine current documentation and workflow practices, and identified which processes were being captured electronically, on paper, or not at all. Subsequently, NMC reviewed the proposed PRIME projects and selected those which aligned with the hospital's overall population health strategy.

Reporting

NMC will integrate patient information from multiple databases and subsequently generate PRIME reports and a dashboard utilizing its SSRS. The selection options on the report dashboard will be organized by measurement year, project and metric.

Monitoring

NMC's PRIME Data Team has established a process to monitor the PRIME metrics by identifying statistical outliers that can then be utilized to target process improvement.

The most significant barrier to meeting the PRIME reporting requirements is resourcing. There are limited FTEs and financial resources to support the required data aggregation, reporting, clinical and care management teams necessary to implement the care transformation outlined by PRIME. As part of NMC's overall Population Health strategy, the hospital is evaluating a potentially new enterprise EHR, a population analytics software platform and creating a robust care management program all of which will be resource intensive.

Section 3: Executive Summary

The objective of PRIME is to accelerate participating entities' efforts (as applicable), to change care delivery, to maximize health care value and to strengthen their ability to successfully perform under risk-based Alternative Payment Methodologies (APMs). This section of the Plan will be used to present each entity's overall goals and specific aims for PRIME. This section should also describe how these efforts will evolve over the course of the five years.

3.1 PRIME Project Abstract [No more than 600 words]

Please address the following components of the Abstract:

1. *Describe the goals* for your 5-year PRIME Plan;*

   Note:

   * *Goals (generally 2-5) are general guidelines that explain what you want to achieve in your hospital or health system. They are usually medium- to long-term and represent program concepts such as "eliminate disparities." These goals may already be a part of your hospital or health system's strategic plan or similar document.*

The PRIME projects are in alignment with NMC's strategic goal of transforming to a patient centric integrated value-based care delivery system. Through consumer-focused care delivery and program offerings, NMC will shift from hospital-based care to community-based care. NMC will drive clinical integration to create a care delivery system that provides enhanced access and patient experience. The organization will pursue targeted interventions through dissemination of best practices and introduce other strategies to elevate overall care delivery system performance.

In anticipation of changing reimbursement and funding decreases, NMC will acquire capabilities, strategies, and implement programs to support fuller forms of risk reimbursements. In Appendix B, Diagrams 1 and 2 demonstrates NMC's process model for identifying target populations and focused population health management structure. Diagram 3 demonstrates a focused approach to managing gaps in care, specifically with transitions from our acute care, Emergency Department, and behavioral health settings. Diagram 4 provides a detailed explanation of how each program must meet a strict set of guidelines for NMC new population health management structure.

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.*

In evaluating our current state of care delivery we have identified gaps and opportunities to optimize our care delivery by focusing on being patient centric, team based, cost

effective, and high quality. To achieve our strategic objectives to become a care delivery system that understands the population it services and importance of focusing on each individual member. Thus, NMC has three transformational aims for participation in PRIME:

- Redesign care so that it is a medical home for patients and a care team to deliver services.
- Obtain foundational Information Technology (IT) infrastructure to support population health management which is based on Diagram 1.
- Implement system-wide processes for monitoring and evaluating individual and population progress in the healthcare system through the use of data analytics, a proven process improvement methodology and implementation of a care management program.

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;*

Natividad Medical Centers (NMC) multi-disciplinary PRIME WIT committee has carefully selected three optional PRIME projects that will assist with the aim to provide evidence-based care, decreasing disparities in care and managed cost of care in alignment with the Triple Aim which strives to provide the experience of care, improve health populations, and reduce per capita costs of healthcare.

Along with the six required PRIME projects, Natividad Medical Center's (NMC) multi-disciplinary PRIME WTI committee has carefully selected these three non-required PRIME Projects, 1.5 The Million Hearts Initiative, 2.6 Chronic Non-Malignant Pain Management and 3.4 Resource Stewardship: Blood Products. Monterey County has several population health challenges, which include heart disease as the leading cause of death (25% of all mortalities in 2010). An epidemic drug usage problem, according to the Monterey County Medical Examiner data, the leading cause of non-natural death in Monterey County is drug overdose. Also, NMC has recently become the county's Level II Trauma center, and NMC's cost of blood products have doubled over the past two years.

With the six required projects and the selection of the three non-required projects, NMC's focus will be to work towards providing evidence-based care, decreasing disparities in care and managing the cost of care in alignment with the "Triple Aim", which strives to improve the experience of care, improve the health of populations, and reduce per capita costs of health care. These projects will enable and NMC to redesign of care, implement appropriate IT technology and implement processes for evaluating and monitoring NMC's patient population.

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*

Natividad Medical Center (NMC) has selected three non-required projects. The 1.5 Million Hearts Initiative and the 2.6 Chronic Non-Malignant Pain Management projects were selected to build on the transformation and redesign of primary care delivery at NMC. The 3.4 Resource Stewardship: Blood Products project provides NMC with the opportunity to tackle an area of high cost for the organization and thus improve the overall stewardship of healthcare resources in Monterey County.

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

Successful execution of this 5-year strategic plan will enable NMC to achieve a patient centric, cost efficient, high quality, and integrated care delivery system with improved access and patient experience to manage population health. This transformation will result in coordinated care between NMC and the Monterey County Health Department Clinic System with seamless transitions of care. NMC will experience a decrease in hospital readmissions and Emergency Department visits due to ambulatory sensitive conditions, and as a result, the Monterey County Department Clinic System should see an increase in ambulatory care visits due to a targeted effort to funnel patient into the clinics for ambulatory sensitive conditions. The focus on preventive care and implementing reliable processes to close the gaps in care will maintain population health. The overall cost of care will decrease because Monterey County patients will receive the right care, at the right place, at the right time.

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.

Natividad Medical Center (NMC) embraces the philosophy that healthcare is a "local" activity at the various points of care. Therefore, NMC's PRIME participation will include implementing an integrated care delivery system with "Program Base Criteria" (Appendix B, Diagram 4) for Population Health Management with the majority of care delivery and care management operations to be delivered within the local clinics. Every program will be cataloged and every program will have a care transition built into it. This means that although NMC will be developing a system-wide Population Health

Management model with core infrastructure, each clinic will be operating in a patient-centric manner so that the unique challenges at each clinic are able to be addressed (Appendix B., Diagrams 4 and 5)

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).

Natividad Medical Center (NMC) has established a multi-disciplinary PRIME Committee, which has been meeting regularly since December, 2015, to oversee the implementation of PRIME. Committee representation includes physicians, key managers, and administration and those with expertise in information technology, case management and quality improvement. Physician representation includes experienced primary care, specialty care and behavioral health care providers.

The PRIME Committee is led by NMC's Clinical Integration and Innovation Officer (CIIO). A project manager has been engaged to coordinate the PRIME projects and to ensure that key milestones of the PRIME program are met. The CIIO is responsible for integration of the PRIME projects in to the organizational strategic plan and works closely with NMC administrators on the execution of the strategic plan.

NMC has also established a PRIME Data Team to oversee the data collection, reporting, and monitoring related to the PRIME metrics.

NMC will prepare and actively manage a data-driven PRIME plan dashboard that will be monitored by NMC's administrative team each quarter. As needed, the CEO and administrative team may elevate issues to the Board of Trustees. The Board of Trustees will receive updates on progress at periodic board meetings.

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.

Natividad Medical Center has developed a strategic plan for optimization healthcare delivery to the populations who have been entrusted in our care. Recognizing that collaboration is essential, the membership of the NMC's PRIME WIT Committee includes representation from various organizations that impact the care related to all of the PRIME projects.

One of the key aims of PRIME participation for NMC is to redesign how care is delivered and in particular to implement a patient-centric model of care. Imbedded in this model of care is the creation and implementation of mechanisms for regular patient/family input and feedback such as a patient/family advisory council and patient/family participation on project teams. By having these committees, it will provide validation that our processes continue to be patient centric and facilitate engagement.

Additionally, NMC is reaching out to community-based organizations that provide support services to NMC patient populations we serve. Examples of the organizations that NMC is developing a relationship with includes the Central Coast Alliance for Health (Monterey County's Managed Medi-Cal Plan) and community based organizations that provide services and solutions for physical and behavioral health. NMC has also reached out to labor unions, city council representatives and California State University, Monterey Bay through the Community Coalition.

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 population served by Natividad Medical Center (NMC) is 56% Hispanic/Latino and this population experiences the greatest healthcare disparities within Monterey County. Under the previous Medicaid Waiver, NMC was able to build a model interpreter services program, managed by the Language Access Services Department. The Language Access Services Department utilizes a three-pronged approach: 1) in-person encounters, 2) encounters facilitated by video technology and 3) encounters facilitated by audio technology, to provide qualified interpreter encounters and meet the language needs of the patients served. Currently over 3,200 qualified interpreter encounters are performed each month by a core staff of 4.5 full-time interpreters and over 50 dual-role staff, who serve as qualified interpreters in addition to functioning in their primary role of registered nurse, nursing assistant, patient service representative, etc. All qualified interpreters have completed a 40-hour course which includes information on cultural norms of the Hispanic/Latino population. This knowledge enables them to be cultural clarifiers during the interpretation encounter, where they provide the necessary cultural framework so that the interpreted message is understood. Language Access Services staff serve on performance improvement teams as cultural advisors, as appropriate. The qualified interpreters at NMC essentially serve as cultural identifiers and mediators throughout the organization and will be utilized to help implement PRIME projects and the strategies necessary to reduce the current healthcare 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.

Natividad Medical Center (NMC) believes that the adoption and use of a framework for performance improvement is instrumental to being able to implement change in an efficient and effective manner that improves the quality, safety and the reliability of care. NMC has adopted the Model for Improvement, as promoted by the Institute for Healthcare Improvement (IHI), for their framework for performance improvement. Staff utilize Lean and Reliable Design principles in their improvement work. Through participation in the previous Medicaid Waiver, NMC was able to apply this methodology throughout the organization. Trained administrators, physician leaders, managers, and supervisors utilize this 7-step framework for implementing change, whether it is a new program or process or when making improvements to an existing process. NMC's Quality Department oversees the program and will provide the necessary leadership for implementing the PRIME projects, improving performance and sustaining improvements achieved after the PRIME program has ended.

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)

In alignment with Natividad Medical Center's (NMC) three transformational aims for PRIME participation, NMC will be utilizing a three-pronged approach for implementing 1.1 Integration of Physical and Behavioral Health: 1) care redesign, 2) IT infrastructure and 3) individual and population monitoring and evaluation. This intentional approach will ensure that all PRIME projects are standardized and that this project does not become a silo in NMC's healthcare delivery system.

Care Redesign: The concept of physical-behavioral health integration is new to NMC. Years one and two of PRIME will focus on education, stakeholder engagement and design of NMC's care model solution. An education program for key stakeholders is essential so that NMC can communicate with common terminology, develop a sense of urgency for change and communicate NMC's vision for change. Once completed, the project team will design and deploy the selected care model solution making sure that care is patient-centric, high quality, cost effective and integrated within the care delivery system. Years three through five of PRIME will focus on implementation, deployment and refinement of the care delivery model.

The Four Quadrant Model for Clinical Integration was selected by Natividad Medical Center (NMC) to use as a model and guide for physical-behavioral health integration. NMC is in the process of completing an infrastructure, capabilities and gap assessment

based on the core components selected for this required project. Once completed, an action plan will be developed for the 5-year PRIME timeline. The Model for Improvement, NMC's performance improvement framework, will be utilized to guide the implementation of the targeted system-wide interventions. NMC will be using the AIMS Center Behavioral Integration Checklist as a tool to determine baseline and annual progress. NMC will work closely with the Monterey County Health Department, learning from how they have piloted and then implemented physical-behavioral integration at several of their clinic locations.

IT Infrastructure: An assessment of NMC's IT infrastructure for physical-behavioral health integration revealed the following: no data analytics program in place, no integrated data warehouse between NMC and the Monterey County Health Department, no ambulatory registry in use at NMC and no mechanism to share quality metric data via a dashboard system. NMC is in the process of developing a five-year IT plan for purchasing and implementing the necessary systems to successfully implement physical-behavioral health integration. Years one and two will involve identifying and purchasing the systems needed and years three through five will focus on implementing and refining use of the new technology. Currently NMC does not have a process or IT capabilities to close gaps in care, or monitor quality and performance measures to optimize patient care. NMC in developing an Optimization of Care strategic plan which has identified as an essential key component the need to have IT capabilities to document, monitor, and enhance quality process and utilization to ensure transition to value-based care.

Individual and Population Monitoring and Evaluation: NMC is working to improve the organization's processes for sharing quality metric data that would enable ongoing individual and population monitoring and evaluation. In years one and two of PRIME, NMC will identify and design the processes needed for success and years three through five will focus on implementation and process refinement.

Implementation of this project will help improve physical and behavioral health outcomes for NMC patients. Current care is very fragmented and occurs in silos, inpatient, outpatient and primary care. This project will, in conjunction with implementing the PCMH Model in project 1.2, will help NMC improve the patient's experience and the efficiency of care delivery.

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)
Applicable	**1.1.2**	Implement a physical-behavioral health integration program that

Check, if applicable	Description of Core Components
	utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration, the Collaborative Care Model, or other Integrated Behavioral Health (IBH) resources from SAMHSA)
Not Applicable	**1.1.3** Integrate appropriate screening tools and decision support into the emergency department (ED) to ensure timely recognition of patients with mental health and substance use disorder problems. Enhanced access to primary care and/or to behavioral health specialists will be integrated into discharge planning for these patents. Use of 24-7 care navigators (e.g., Community Physician Liaison Program) may be used to support linkages to primary care providers (PCPs), mental health (MH) and substance use disorder (SUD) specialists and behavioral health and other community services through the discharge process.
Applicable	**1.1.4** Integrate physical and behavioral health, either through implementation of a new program or an expansion of an existing program, from pilot sites to hospital and health system primary care sites or from single populations to multiple populations (e.g., obesity, diabetes, maternal, infant, and child care, end-of-life care, chronic pain management).
Applicable	**1.1.5** Patient-Centered Medical Home (PCMH) and behavioral health providers will: • Collaborate on evidence based standards of care including medication management and care engagement processes. • Implement case conferences/consults on patients with complex needs.
Not Applicable	**1.1.6** Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families.
Not Applicable	**1.1.7** Ensure systems are in place to support patient linkages to appropriate specialty physical, mental and SUD services. Preventive care screenings, including behavioral health screenings (e.g., PHQ-2, PHQ-9, SBIRT), will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including the provision of brief interventions (e.g., motivational interviewing techniques) to ensure access for further evaluation and treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.

Check, if applicable	Description of Core Components
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.
Not Applicable	**1.1.10** Ensure the development of a single treatment plan that includes the patient's behavioral health issues, medical issues, substance abuse, social and cultural and linguistic needs. This includes incorporating traditional medical interventions, as well as non-traditional interventions such as gym memberships, nutrition monitoring, healthy lifestyle coaching, or access to culturally and linguistically appropriate peer-led wellness and symptom management groups.
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.
Applicable	**1.1.13** Implement technology enabled data systems to support pre-visit planning, point of care delivery, care plan development, population/panel management activities, coordination and patient engagement. Develop programs to implement telehealth, eReferral/eConsult to enhance access to behavioral health services.
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

Check, if applicable	Description of Core Components
	to the best of their abilities and credentials. • Providing ongoing staff training on care model.
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)

In alignment with Natividad Medical Center's (NMC) three transformational aims for PRIME participation, NMC will be utilizing a three-pronged approach for implementing 1.2 Ambulatory Redesign: Primary Care: 1) care redesign, 2) IT infrastructure and 3) individual and population monitoring and evaluation. This intentional approach will ensure that all PRIME projects are standardized and that this project does not become a silo in NMC's healthcare delivery system.

Care Redesign: The concepts of patient-centered medical home (PCMH) and population health management (PHM) are new to NMC. Years one and two of PRIME will focus on education, stakeholder engagement and design of NMC's care model solution. An education program for key stakeholders is essential so that NMC can communicate with common terminology, develop a sense of urgency for change and communicate NMC's vision for change. Once completed, the project team will design and deploy the selected care model solution making sure that care is patient-centric, high quality, cost effective and integrated within the care delivery system. Years three through five of PRIME will focus on implementation, deployment and refinement of the care delivery model.

Natividad Medical Center (NMC) will be utilizing the NCQA (National Committee for Quality Assurance) approach for PCMH transformation. NMC is in the process of completing an infrastructure, capabilities and gap assessment based on the NCQA standards and the core components selected for this required project. Once completed, an action plan will be developed for the 5-year PRIME timeline. The Model for Improvement, NMC's performance improvement framework, will be utilized to guide the implementation of the targeted system-wide interventions. NMC will be working closely with the Monterey County Health Department (MCHD) on this project. One of the MCHD clinics has achieved PCMH certification through NCQA and MCHD has implemented elements of the model in their other clinic locations. This approach will provide system-wide standardization for how care is being delivered in the Monterey County and NMC clinics.

IT Infrastructure: An assessment of NMC's IT infrastructure to implement PHM revealed the following: no data analytics program in place, no integrated data warehouse between NMC and the Monterey County Health Department, no ambulatory registry in use at NMC and no mechanism to share quality metric data via a dashboard system. The organization is in the process of developing a five-year IT plan for purchasing and implementing the necessary systems to successfully implement PHM. Years one and two will involve identifying and purchasing the systems needed and years three through five will focus on implementing and refining use of the new technology. Currently NMC does not have a process or IT capabilities to close gaps in care, or monitor quality and performance measures to optimize patient care. NMC in developing their Optimization of Care strategic plan has identified as an essential key component the need to have IT capabilities to document, monitor, and enhance quality process and utilization to ensure transition to value-based care.

Individual and Population Monitoring and Evaluation: NMC is working to improve the organization's processes for sharing quality metric data that would enable ongoing individual and population monitoring and evaluation. In years one and two of PRIME, NMC will identify and design processes needed for success and years three through five will focus on implementation and process refinement.

The patients of Monterey County will benefit from NMC's primary care transformation. The infrastructure will be developed so that patients will consistently receive recommended preventive health services, access to care will be improved, and a standard process for patient engagement will be implemented. The staff at NMC's primary care clinics will experience improvement in job satisfaction and engagement as they implement team-based care.

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

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

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

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

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

In alignment with Natividad Medical Center's (NMC) three transformational aims for PRIME participation, NMC will be utilizing a three-pronged approach for implementing 1.3 Ambulatory Redesign: Specialty Care: 1) care redesign, 2) IT infrastructure and 3) individual and population monitoring and evaluation. This intentional approach will ensure that all PRIME projects are standardized and that this project does not become a silo in NMC's healthcare delivery system.

Care Redesign: The concepts of patient-centered medical home neighborhood (PCMH-N) and population health management (PHM) are new to NMC. Years one and two of

PRIME will focus on developing PCMH capabilities in our primary care clinics to allow interface with the specialist clinics via PCMH-N. It is essential to understand that we do not have any of the capabilities currently in place for PCMH or PCMH-N. Education is a key component as we begin this journey on transforming our practices to incorporate PCMH and PCMH-N model capabilities. It will require collaboration between primary care and specialist care.

Using the foundation of the patient centered medical home, we are focusing on physician led care team to meet patient health goals and needs, and assist in coordinating patient care across settings. Using this process, the patient is more likely to receive the right care at the right time at the right setting. NMC's focus will be to change episodic care for individual patients to proactive care for the population of patients we serve. By using the PCMH-N model NMC will focus on closing gaps in care and reducing fragmentation of care across various settings. The goal is to incorporate basic PCMH-N principles into specialist practices and coordination care between PCP's. Years three through five of PRIME will focus on implementation, deployment and refinement of PCMH and PCMH-N and our care delivery model (Appendix B, Diagram 2).

Natividad Medical Center (NMC) is in the process of completing an infrastructure, capabilities and gap assessment based on the core components selected for this required project. Once completed, an action plan will be developed for the 5-year PRIME timeline. The Model for Improvement, NMC's performance improvement framework, will be utilized to guide the implementation of the targeted system-wide interventions.

IT Infrastructure: An assessment of NMC's IT infrastructure to implement PHM revealed the following: no data analytics program in place, no integrated data warehouse between NMC and the Monterey County Health Department, no ambulatory registry in use at NMC and no mechanism to share quality metric data via a dashboard system. The organization is in the process of developing a five-year IT plan for purchasing and implementing the necessary systems to successfully implement PHM. Years one and two will involve identifying and purchasing the systems needed and years three through five will focus on implementing and refining use of the new technology. Currently NMC does not have a process or IT capabilities to close gaps in care, or monitor quality and performance measures to optimize patient care. NMC in developing their Optimization of Care strategic plan has identified as an essential key component the need to have IT capabilities to document, monitor, and enhance quality process and utilization to ensure transition to value-based care.

Individual and Population Monitoring and Evaluation: NMC is working to improve the organization's processes for sharing quality metric data that would enable ongoing

individual and population monitoring and evaluation. Several approaches have been attempted in the past with varying degrees of success. In years one and two of PRIME, NMC will identify and design processes needed for success and years three through five will focus on implementing and refining the processes.

Monterey County patients will benefit from the transformation of Specialty Care at NMC. Current closed-loop processes for Specialty Care at NMC are manual and unreliable. By implementing this project, NMC will redesign the referral management and reporting processes with appropriate technology solutions so that patients receive appropriate specialty care and primary care providers receive communication of the outcome of the referral.

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

Check, if applicable	Description of Core Components
Not Applicable	**1.3.1** Develop a specialty care program that is broadly applied to the entire target population.
Applicable	**1.3.2** Conduct a gap analysis to assess need for specialty care including mental health and SUD services (analysis to include factors impacting ability to access specialty care), and the current and ideal state capacity to meet that need. Benchmark to other CA Public Health Care systems.
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.
Not 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.

Check, if applicable	Description of Core Components
Not Applicable	**1.3.8** Ensure that clinical teams engage in team- and evidence-based care.
Applicable	**1.3.9** Increase staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the care model.
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.
Applicable	**1.3.12** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population management activities and care coordination/transitions of care. Ensure that timely, relevant, and actionable data are used to support patient engagement, PCP collaboration, and drive clinical, operational and strategic decisions including continuous quality improvement (QI) activities.
Not Applicable	**1.3.13** Implement EHR technology that meets MU standards.
Not Applicable	**1.3.14** Patients have care plans and are engaged in their care. Patients with chronic disease (including MH/SUD conditions) managed by specialty care have documented patient-driven, self-management goals reviewed at each visit.
Not Applicable	**1.3.15** Improve medication adherence.
Applicable	**1.3.16** Implement population management strategies for patients in need of preventive services, with chronic conditions, or with recurring long term surveillance needs.
Not Applicable	**1.3.17** Implement or expand use of telehealth based on DPH/DMPH capacity to address patient and PCP barriers to accessing specialty expertise. Implement a telehealth platform with communication modalities that connect between specialty care and primary care (e.g., eConsult/eReferral).
Applicable	**1.3.18** Demonstrate engagement of patients in the design and

Check, if applicable	Description of Core Components
	implementation of the project.
Applicable	**1.3.19** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.
Not Applicable	**1.3.20** Test use of novel performance metrics for redesigned specialty care models.

☒ 1.5 – Million Hearts Initiative

NMC has selected PRIME project 1.5 Million Hearts Initiative as the non-required project for domain one. This project is important for Monterey County because heart disease is the leading cause of death, 25% of all mortalities in 2010. Additionally, 11% of adults in Monterey County report being a current smoker.

In alignment with NMC's three transformational aims for PRIME participation, NMC will be utilizing a three-pronged approach for implementing the 1.5 Million Hearts Initiative: 1) care redesign, 2) IT infrastructure and 3) individual and population monitoring and evaluation. This intentional approach will ensure that all PRIME projects are standardized and that this project does not become a silo in NMC's healthcare delivery system.

Care Redesign: The concepts of population health management (PHM) and reducing disparities in care are new to NMC. Years one and two of PRIME will focus on education, stakeholder engagement and design of NMC's care model solution. An education program for key stakeholders is essential so that NMC can communicate with common terminology, develop a sense of urgency for change and communicate NMC's vision for change. Once completed, the project team will design and deploy the selected care model solution making sure that care is patient-centric, high quality, cost effective and integrated within the care delivery system. Years three through five of PRIME will focus on implementation, deployment and refinement of the care delivery model.

NMC is in the process of completing an infrastructure, capabilities and gap assessment based on the core components selected for this project, including the recommendations from the US Preventive Services Task Force (USPSTF). Once completed, an action plan will be developed for the 5-year PRIME timeline. The Model for Improvement, NMC's performance improvement framework, will be utilized to guide the implementation of the targeted system-wide interventions.

IT Infrastructure: An assessment of NMC's IT infrastructure to implement PHM and work on reducing disparities in care revealed the following: no data analytics program in place, no integrated data warehouse between NMC and the Monterey County Health Department, no ambulatory registry in use at NMC and no mechanism to share quality metric data via a dashboard system. The organization is in the process of developing a five-year IT plan for purchasing and implementing the necessary systems to successfully implement PHM. Years one and two will involve identifying and purchasing the systems needed and years three through five will focus on implementing and refining use of the new technology. Currently NMC does not have a process or IT capabilities to close gaps in care, or monitor quality and performance measures to optimize patient care. NMC in developing their Optimization of Care strategic plan has

identified as an essential key component the need to have IT capabilities to document, monitor, and enhance quality process and utilization to ensure transition to value-based care.

Individual and Population Monitoring and Evaluation: NMC is working to improve the organization's processes for sharing quality metric data that would enable ongoing individual and population monitoring and evaluation. In years one and two of PRIME, NMC will identify and design processes needed for success and years three through five will focus on implementation and process refinement.

The population of Monterey County will benefit from the successful implementation of the core components of this project. The quality of care provided by NMC will be improved by practicing evidence-based care. Mortality associated with heart disease will decrease and disparities in care will be reduced due to patients receiving targeted prevention services.

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

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

Check, if applicable	Description of Core Components
	those that address the social determinants of health, as appropriate.
Applicable	**1.5.7** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. • Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts.
Applicable	**1.5.8** Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.

Please complete the summary chart:

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

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

☒ 2.1 – Improved Perinatal Care (required for DPHs)

In alignment with Natividad Medical Center's (NMC) three transformational aims for PRIME participation, NMC will be utilizing a three-pronged approach for implementing 2.1 Improvements in Perinatal Care: 1) care redesign, 2) IT infrastructure and 3) individual and population monitoring and evaluation. This intentional approach will ensure that all PRIME projects are standardized and that this project does not become a silo in NMC's healthcare delivery system.

Care Redesign: Over the past five years, NMC has focused on making improvements in Perinatal Care and has achieved success. NMC was recently named as one of 33 high performing hospitals in maternity care in California by the California HealthCare Foundation. Hospital performance was rated in four key areas of maternity care: low-risk C-section rates, episiotomy rates, rates of exclusive breastfeeding before discharge and VBAC (vaginal birth after C-section) rates. NMC will build on this strong foundation in implementing this PRIME project. NMC plans to focus on improving care transitions for patients with co-morbid conditions and continue work on improving exclusive breastfeeding.

Natividad Medical Center (NMC) recognizes the essential need Optimization Care Delivery Strategic Plan, we have identified that transition of care and specific workflows are integral to coordination and continuity of healthcare for high risk patients. The NMC care model (Diagram 2) portrays our processes, having our patient with the care team at the center, identifying potential point of care the patient may utilize, what programs would be beneficial to them, and have transitions of care links built into them. Diagram 3, demonstrations specific transitions of care programs, with the workflows that we planning on implementing at NMC.

IT Infrastructure: NMC is in the process of conducting an assessment regarding the information technology needs of the organization's Perinatal Services related to PRIME participation and is developing a five-year IT plan for purchasing and implementing the necessary systems to succeed in this endeavor. Years one and two will involve identifying and purchasing the systems needed and years three through five will focus on implementing and refining use of the new technology. Currently NMC does not have a process or IT capabilities to close gaps in care, or monitor quality and performance measures to optimize patient care. NMC in developing their Optimization of Care strategic plan has identified as an essential key component the need to have IT capabilities to document, monitor, and enhance quality process and utilization to ensure transition to value-based care.

Individual and Population Monitoring and Evaluation: NMC is working to improve the organization's processes for sharing quality metric data that would enable ongoing individual and population monitoring and evaluation. Several approaches have been attempted in the past with varying degrees of success. In years one and two of PRIME, NMC will identify and design processes needed for success and years three through five will focus on implementing and refining the processes.

Perinatal patients that deliver at NMC or receive perinatal and post-partum care at NMC or the Monterey County Health Department Clinics will benefit from this project. In particular NMC will be focusing on improved coordination of care for women with co-morbid conditions in the post-partum period. Evidence-based protocols will be implemented throughout system so that patients received consistent, high quality and cost effective care.

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.
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)

In alignment with Natividad Medical Center's (NMC) three transformational aims for PRIME participation, NMC will be utilizing a three-pronged approach for implementing 2.2 Care Transitions: Integration of Post-Acute Care: 1) care redesign, 2) IT infrastructure and 3) individual and population monitoring and evaluation. This intentional approach will ensure that all PRIME projects are standardized and that this project does not become a silo in NMC's healthcare delivery system.

Care Redesign: The concepts of patient-centered medical home neighborhood (PCMH-N) and population health management (PHM) are new to NMC. In years one and two of PRIME, NMC will focus on developing PCMH-N capabilities in our primary clinics to allow interface with our Post-Acute care facilities via PCMH-N, such as SNF's and Rehabilitation Units. It is essential to understand that we do not have the capabilities currently in place for PCMH or PCMH-N. Education is a key component as we begin this journey on transforming our practices to incorporate PCMH and PCMH-N model capabilities. It will require our Acute Care to establish transitions flows and communication with community-based providers, home-base care, and post discharge communication as display via Diagram 3.

Using the foundation of the patient centered medical home, we are focusing on physician led care team to meet patient health goals and needs and assist in coordinating patient care across settings. Using this process, the patient is more likely to receive the right care at the right time at the right setting. NMC's focus will be to change episodic care for individual patients to proactive care for the population of patients we serve. Using PCMH-N model we will focus on closing gaps in care and reducing fragmentation of care across various settings. The goal is to incorporate basic PCMH-N principles into acute care and ambulatory care practices and coordination care between acute care and post-acute care integration. Years three through five of PRIME will focus on implementation, deployment and refinement of PCMH and PCMH-N and our care delivery model (Appendix B, Diagram 2).

NMC has recently started implementing an Outpatient Case Management Program which will provide the foundation for this PRIME project. The Case Management program will evaluate several items, ranging from identifying admission / population criteria and best practices to implement transitions of care from acute to post-acute care, which is displayed in Diagram 3. Natividad Medical Center (NMC) is in the process of completing an infrastructure, capabilities and gap assessment based on the core components selected for this required project. Once completed, an action plan will be developed for the 5-year PRIME timeline. The Model for Improvement, NMC's performance improvement framework, will be utilized to guide the implementation of the targeted system-wide interventions. NMC will work to improve the quality and effectiveness of the discharge process by utilizing the AHRQ Guide to Reducing Medicaid Readmissions and the RED Toolkit as key resources. The Coleman Care Transitions Intervention model will be used to support patients and family caregivers in developing self-management skills. Plans are underway to utilize the LACE Index Scoring Tool for assessing readmission risk.

Natividad Medical Center (NMC) recognizes the essential need Optimization Care Delivery Strategic Plan, we have identified that transition of care and specific workflows are integral to coordination and continuity of healthcare for high risk patients. The NMC care model (Diagram 2) portrays our processes, having our patient with the care team at the center, identifying potential point of care the patient may utilize, what programs

would be beneficial to them, and have transitions of care links built into them. Diagram 3, demonstrations specific transitions of care programs, with the workflows that we planning on implementing at NMC.

IT Infrastructure: An assessment of NMC's IT infrastructure to implement PHM and redesigning care transitions revealed the following: no data analytics program in place, no integrated data warehouse between NMC and the Monterey County Health Department, no ambulatory registry in use at NMC and no mechanism to share quality metric data via a dashboard system. The organization is in the process of developing a five-year IT plan for purchasing and implementing the necessary systems to successfully implement PHM. Years one and two will involve identifying and purchasing the systems needed and years three through five will focus on implementing and refining use of the new technology. Currently NMC does not have a process or IT capabilities to close gaps in care, or monitor quality and performance measures to optimize patient care. NMC in developing their Optimization of Care strategic plan has identified as an essential key component the need to have IT capabilities to document, monitor, and enhance quality process and utilization to ensure transition to value-based care.

Individual and Population Monitoring and Evaluation: NMC is working to improve the organization's processes for sharing quality metric data that would enable ongoing individual and population monitoring and evaluation. In years one and two of PRIME, NMC will identify and design processes needed for success and years three through five will focus on implementation and process refinement.

Patients that are discharged from NMC acute care locations will benefit from the success of this project. The goal is for them to experience seamless transitions in care due to improved communication and coordination between inpatient and outpatient care teams, increased capacity for self-management of medical conditions and an improved overall patient experience. NMC will see a reduction in avoidable acute care utilization and see a reduction in disparities in care.

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

Check, if applicable	Description of Core Components
Applicable	**2.2.1** Develop a care transitions program or expand a care transitions program to additional settings (e.g., emergency department), or to additional populations, using or adapting at least one nationally recognized care transitions program methodology.
Applicable	**2.2.2** Establish or expand on a system to track and report readmission rates, timeliness of discharge summaries, and other transition processes, and investigate system-specific root causes/risk factors for

Check, if applicable	Description of Core Components
	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.
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.
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.

Check, if applicable	Description of Core Components
	• Written transition care plan for patient and caregiver. • Timely communication and coordination with receiving practitioner. Community-based support for the patient and caregiver post hospitalization focusing on self-care requirements and follow-up care with primary and specialty care providers.
Applicable	**2.2.8** Engage with local health plans to develop transition of care protocols that ensure: coordination of care across physical health, substance use disorder and mental health spectrum will be supported; identification of and follow-up engagement with PCP is established; covered services including durable medical equipment (DME) will be readily available; and, a payment strategy for the transition of care services is in place.
Applicable	**2.2.9** Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**2.2.10** Increase multidisciplinary team engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on care model.
Applicable	**2.2.11** Implement a system for continual performance feedback and rapid cycle improvement that uses standard process improvement methodology and that includes patients, front line staff and senior leadership.

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

In alignment with Natividad Medical Center's (NMC) three transformational aims for PRIME participation, NMC will be utilizing a three-pronged approach for implementing 2.3 Complex Care Management for High Risk Medical Populations: 1) care redesign, 2) IT infrastructure and 3) individual and population monitoring and evaluation. This intentional approach will ensure that all PRIME projects are standardized and that this project does not become a silo in NMC's healthcare delivery system.

Care Redesign: The concepts of patient-centered medical home neighborhood (PCMH-N) and population health management (PHM) are new to NMC. In years one and two of PRIME, NMC will focus on developing PCMH-N capabilities in our primary clinics to allow interface with our various healthcare points of care to better manage our High Risk Populations via PCMH-N. Education is a key component as we begin this journey

on transforming our practices to incorporate PCMH and PCMH-N model capabilities. It will require our point of care locations, such as ED and our clinic systems to establish transitions flows and communication with community base providers, other local hospitals, and outside clinics as displayed via Diagram 3.,

Using the foundation of the patient centered medical home, we are focusing on physician led care team to meet patient health goals and needs and assist in coordination patient care across settings. Using this process, the patient is more likely to receive the right care at the right time at the right setting. NMC's focus will be to change episodic care for individual patients to proactive care for the population of patients we serve. Using PCMH-N model we will focus on closing gaps in care and reducing fragmentation of care across various settings. The goal is to incorporate basic PCMH-N principles into our ED and clinic systems and coordination care between our points of care integration. Years three through five of PRIME will focus on implementation, deployment and refinement of PCMH and PCMH-N and our care delivery model (Appendix B, Diagram 2).

NMC has recently started implementing an Outpatient Case Management Program which will provide the foundation for this PRIME project. The Case Management program will evaluate several items, ranging from identifying admission / population criteria and best practices to implement transitions of care throughout our points of care, such as ED and Clinic Systems. Natividad Medical Center (NMC) is in the process of completing an infrastructure, capabilities and gap assessment based on the core components selected for this required project. Once completed, an action plan will be developed for the 5-year PRIME timeline. The Model for Improvement, NMC's performance improvement framework, will be utilized to guide the implementation of the targeted system-wide interventions. NMC will use the California Quality Collaborative program methodology to guide the implementation of a complex care management program. While the California Quality Collaborative is not a specific care model, the program methodology includes strategies such as, Practice Transformation, Improving Medically Complex Care, Managing Total Cost of Care, and Building Capacity for Improvement, which NMC will be utilizing to help our care model implementation. Also, plans are underway to utilize the LACE Index Scoring Tool for assessing readmission risk.

IT Infrastructure: An assessment of NMC's IT infrastructure to implement PHM and manage complex patients revealed the following: no data analytics program in place, no integrated data warehouse between NMC and the Monterey County Health Department, no ambulatory registry in use at NMC and no mechanism to share quality metric data via a dashboard system. The organization is in the process of developing a five-year IT plan for purchasing and implementing the necessary systems to successfully implement PHM. Years one and two will involve identifying and purchasing the systems needed and years three through five will focus on implementing and

refining use of the new technology. Currently NMC does not have a process or IT capabilities to close gaps in care, or monitor quality and performance measures to optimize patient care. NMC in developing their Optimization of Care strategic plan has identified as an essential key component the need to have IT capabilities to document, monitor, and enhance quality process and utilization to ensure transition to value-based care.

Individual and Population Monitoring and Evaluation: NMC is working to improve the organization's processes for sharing quality metric data that would enable ongoing individual and population monitoring and evaluation. In years one and two of PRIME, NMC will identify and design processes needed for success and years three through five will focus on implementation and process refinement.

Complex patients that are discharged from NMC and receive primary care at NMC or the Monterey County Health Department will benefit from the success of this project. The goal is for them to experience seamless transitions in care due to improved communication and coordination between inpatient and outpatient care teams, increased capacity for self-management of medical conditions and an improved overall patient experience. NMC will see a reduction in avoidable acute care utilization and see a reduction in disparities in care.

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

Check, if applicable	Description of Core Components
Applicable	**2.3.1** Develop a complex care management program at one site or with one defined cohort, or expand an existing program from a pilot site to all sites or to additional high-risk groups and demonstrate engagement of patients in the design and implementation of the project.
Applicable	**2.3.2** Utilize at least one nationally recognized complex care management program methodology.
Applicable	**2.3.3** Identify target population(s) and develop program inclusion criteria based on quantitative and qualitative data (e.g., acute care utilization, lack of primary care utilization, number of high-risk medical mental or SUD conditions, polypharmacy, primary care input, functional status, patient activation, social support or other factors). Include patient factors associated with a higher probability of being impacted by complex care management.
Applicable	**2.3.4** Conduct a qualitative assessment of high-risk, high-utilizing patients.
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

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

☒ 2.6 – Chronic Non-Malignant Pain Management

NMC has selected PRIME project 2.6 Chronic Non-Malignant Pain Management as the non-required project for domain two. The epidemic use of pain drugs has become a major concern for healthcare providers in NMC and in Monterey County. Work on this project provides NMC with an opportunity for system-wide standardization in the approach to chronic non-malignant pain management.

In alignment with Natividad Medical Center's (NMC) three transformational aims for PRIME participation, NMC will be utilizing a three-pronged approach for implementing 2.6 Chronic Non-Malignant Pain Management: 1) care redesign, 2) IT infrastructure and 3) individual and population monitoring and evaluation. This intentional approach will ensure that all PRIME projects are standardized and that this project does not become a silo in NMC's healthcare delivery system.

Care Redesign: The concepts of patient-centered medical home neighborhood (PCMH-N) and population health management (PHM) are new to NMC. In year one and two of PRIME, NMC will focus on developing PCMH-N capabilities in our primary clinics to allow our staff to better manage chronic non-malignant pain management issues via PCMH-N. Education is a key component as we being this journey on transforming our practices to incorporate PCMH and PCMH-N model capabilities. It will require our clinic systems to establish transition flows and communication with local healthcare providers, community based providers, other local hospitals, and outside clinics displayed via Diagram 3, under the behavioral health section.

Using the foundation of the patient centered medical home, we are focusing on physician led care team to meet patient health goals and needs and assist in coordination patient care across settings. Using this process, the patient is more likely to receive the right care at the right time at the right setting. NMC's focus will be to change episodic care for individual patient to proactive care for the population of patients we serve. Using PCMH-N model we will focus on closing gaps in care and reducing fragmentation of care across various settings. The goal is to incorporate basic PCMH-N principles into our ED and clinic systems and coordination care between our points of care integration.

NMC has recently started implementing an Outpatient Case Management Program which will provide the foundation for this PRIME Project. The Case Management program will evaluate several items, ranging from identifying admission / population criteria and best practices to implement transitions of care throughout points of care, such as ED and Clinic System.

IT Infrastructure: NMC is in the process of conducting an assessment regarding the information technology needs a Chronic Non-malignant Pain Management Program related to PRIME participation and is developing a five-year IT plan for purchasing and implementing the necessary systems to succeed in this endeavor. Years one and two will involve identifying and purchasing the systems needed and years three through five will focus on implementing and refining use of the new technology. Currently NMC does not have a process or IT capabilities to close gaps in care, or monitor quality and performance measures to optimize patient care. NMC in developing their Optimization of Care strategic plan has identified as an essential key component the need to have IT capabilities to document, monitor, and enhance quality process and utilization to ensure transition to value-based care.

Individual and Population Monitoring and Evaluation: NMC is working to improve the organization's processes for sharing quality metric data that would enable ongoing individual and population monitoring and evaluation. In years one and two of PRIME, NMC will identify and design processes needed for success and years three through five will focus on implementing and refining the processes.

Beneficiaries of the successful implementation of a Chronic Non-Malignant Pain Management program will be the patients, providers and the organization. The patients will have improved function and/or quality of life. The providers will have improved job satisfaction, as they will have new strategies for managing this challenging patient population. NMC will experience a decrease in the rate of Emergency Department visits and/or acute care utilization related to opioid overdose of patients with chronic pain.

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

Check, if applicable	Description of Core Components
Applicable	**2.6.1** Develop an enterprise-wide chronic non-malignant pain management strategy.
Applicable	**2.6.2** Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**2.6.3** Implement or adapt a state or nationally recognized methodology for the assessment and management of chronic pain.
Applicable	**2.6.4** Implement protocols for primary care management of patients with chronic pain including: • A standard standardized Pain Care Agreement. • Standard work and policies to support safe prescribing practices. • Comprehensive pain history including psycho/social evaluation, functional evaluations, care plan, pain medication risk/benefit informed consents, ongoing monitoring of plan/outcomes (e.g., use of standardized monitoring template for follow-up visits for CNP), aberrant behavior screening and management protocols. • Guidelines regarding maximum acceptable dosing.
Applicable	**2.6.5** Provide culturally, linguistically and literacy level-appropriate patient education on the pathology of chronic pain, rationale for rehabilitation and expected goals of treatment.
Not Applicable	**2.6.6** Coordinate a chronic pain care team that minimally consists of a physician champion and medical support staff. Suggestions for care clinicians from other disciplines include occupational and physical therapy, behavioral health, pharmacy, substance use disorder specialists, neurology, occupational medicine, anesthesiology/pain management,

Check, if applicable	Description of Core Components
	home care, social work, and physical medicine and rehabilitation.
Applicable	**2.6.7** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, and team based population/panel management and care coordination.
Not Applicable	**2.6.8** Determine population ICD-9/ICD-10 codes for data collection that is unique to patients with chronic pain on opioids and develop a registry for pain assessments, care agreements, medication refill standing orders and urine toxicology screening.
Not Applicable	**2.6.9** Utilize provider activity report card to provide feedback to providers on how their chronic pain management practice compares to peers and benchmarks.
Not Applicable	**2.6.10** Establish a policy for monitoring and maintaining opioid agreements for prescription refills with other clinics, pharmacies, dentists and specialists.
Applicable	**2.6.11** Develop a process for scheduling pain focused follow-up patient visits to ensure that patients receive refills in a timely manner while also receiving recommended monitoring for signs of diversion or misuse.
Not Applicable	**2.6.12** Develop staff and clinician training regarding the organization's process for managing patients with chronic non-malignant pain.
Not Applicable	**2.6.13** Train providers to identify signs of prescription opioid use disorders and provide treatment options for patients diagnosed with opioid use disorders, including suboxone treatment, referral to methadone maintenance, referral to inpatient and outpatient substance use disorder treatment facilities, and referral to needle exchanges.
Not Applicable	**2.6.14** Develop and implement protocols for prescribing naloxone to patients receiving opioids for chronic pain.
Not Applicable	**2.6.15** Identify standardized multidimensional pain assessment, functional assessment, psychological assessment, and opioid assessment tools that meet the needs of the care clinicians and are appropriate for the patient populations.
Not Applicable	**2.6.16** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. Timely, relevant and actionable data is used to support patient.

Please complete the summary chart:

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

Section 4.3 – Domain 3: Resource Utilization Efficiency

☒ 3.4 – Resource Stewardship: Blood Products

Natividad Medical Center (NMC) has selected PRIME project 3.4 Resource Stewardship: Blood Products as the non-required project for domain three. Implementation of a Patient Blood Management (PBM) Program is core to this project and NMC will be utilizing the American Association of Blood Banks (AABB) PBM methodology as a guide for this important endeavor. This project is important for NMC because the cost of blood products for the organization has nearly doubled over the past two years due to overuse of blood products and implementation of a Level II Trauma Service. NMC is also concerned about the under-reporting of transfusion reactions.

In alignment with Natividad Medical Center's (NMC) three transformational aims for PRIME participation, NMC will be utilizing a three-pronged approach for implementing 3.4 Resource Stewardship: Blood Products: 1) care redesign, 2) IT infrastructure and 3) individual and population monitoring and evaluation. This intentional approach will ensure that all PRIME projects are standardized and that this project does not become a silo in NMC's healthcare delivery system.

Care Redesign: The principal goal of a PBM program is to improve patient outcomes through implementation of evidence-based blood transfusion guidelines and clinician education about strategies and techniques to minimize transfusion and manage bleeding. NMC will be implementing standardized clinician performance measures to drive clinician behavior change.

NMC is in the process of completing an infrastructure, capabilities and gap assessment based on AABB recommendations related to PBM and the core components selected for this project. NMC will focus on implementing a process of evaluating impact of blood product use including appropriateness of use, adequacy of documentation, safety implications, and cost. The Model for Improvement, NMC's performance improvement framework, will be utilized to guide the implementation of the targeted interventions. To improve targeted intervention identification, NMC will plan to implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. Developing an organization wide dashboard to track provider level blood use patterns will assist with the performance improvement processes going forward.

IT Infrastructure: NMC is in the process of conducting an assessment regarding the information technology needs of a PBM program related to PRIME participation and is developing a five-year IT plan for purchasing and implementing the necessary systems to succeed in this endeavor. Years one and two will involve identifying and purchasing the systems needed and years three through five will focus on implementing and

refining use of the new technology. Currently NMC does not have a process or IT capabilities to close gaps in care, or monitor quality and performance measures to optimize patient care. NMC in developing their Optimization of Care strategic plan has identified as an essential key component the need to have IT capabilities to document, monitor, and enhance quality process and utilization to ensure transition to value-based care.

Individual and Population Monitoring and Evaluation: NMC is working to improve the organization's processes for sharing quality metric data that would enable ongoing individual and population monitoring and evaluation. In years one and two of PRIME, NMC will identify and design processes needed for success and years three through five will focus on implementation and process refinement.

Patients at NMC who receive blood transfusions will be the key beneficiary of an effective PBM. An evidence-based approach to blood utilization leading to blood usage reductions has the potential to reduce the risk of an adverse reaction or an infection related to the transfusion and to shorten hospital stays. Responsible use of this precious commodity, the blood supply, will result in a decrease in the total cost of care. In addition to the cost of the blood product, the total cost of care includes laboratory testing, medications from pharmacy, transfusion and monitoring equipment as well as nursing, laboratory and pharmacy labor.

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

Check, if applicable	Description of Core Components
Applicable	**3.4.1** Implement or expand a patient blood products management (PBM) program.
Applicable	**3.4.2** Implement or expand a Transfusion Committee consisting of key stakeholder physicians and medical support services, and hospital administration.
Applicable	**3.4.3** Utilize at least one nationally recognized patient blood management program methodology (e.g., The Joint Commission, AABB).
Applicable	**3.4.4** Develop processes for evaluating impact of blood product use including appropriateness of use, adequacy of documentation, safety implications, cost, and departmental budget impact. Develop a data analytics process to track these and other program metrics.
Not Applicable	**3.4.5** Establish standards of care regarding use of blood products, including: Use of decision support/CPOE, evidence based guidelines and medical criteria to support and/or establish standards.
Applicable	**3.4.6** Implement a system for continual performance feedback and rapid

Check, if applicable	Description of Core Components
	cycle improvement that includes patients, front line staff and senior leadership.
Not Applicable	**3.4.7** Develop organization-wide dashboards to track provider level blood use patterns. Dashboard to include comparisons to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.
Not Applicable	**3.4.8** Participate in the testing of novel metrics for PBM programs.

Please complete the summary chart:

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

Section 5: Project Metrics and Reporting Requirements

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

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

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

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

Section 6: Data Integrity

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

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

Section 7: Learning Collaborative Participation

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

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

Section 8: Program Incentive Payment Amount

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

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

- DY 11 $ 31,799,600
- DY 12 $ 31,799,600
- DY 13 $ 31,799,600
- DY 14 $ 28,619,640
- DY 15 $ 24,326,694

Total 5-year prime plan incentive amount: $ 148,345,134

Section 9: Health Plan Contract (DPHs Only)

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

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

Section 10: Certification

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

Appendix A- Infrastructure Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
1.				
2.				
3.				
4.				
5.				

Appendix B- Diagrams

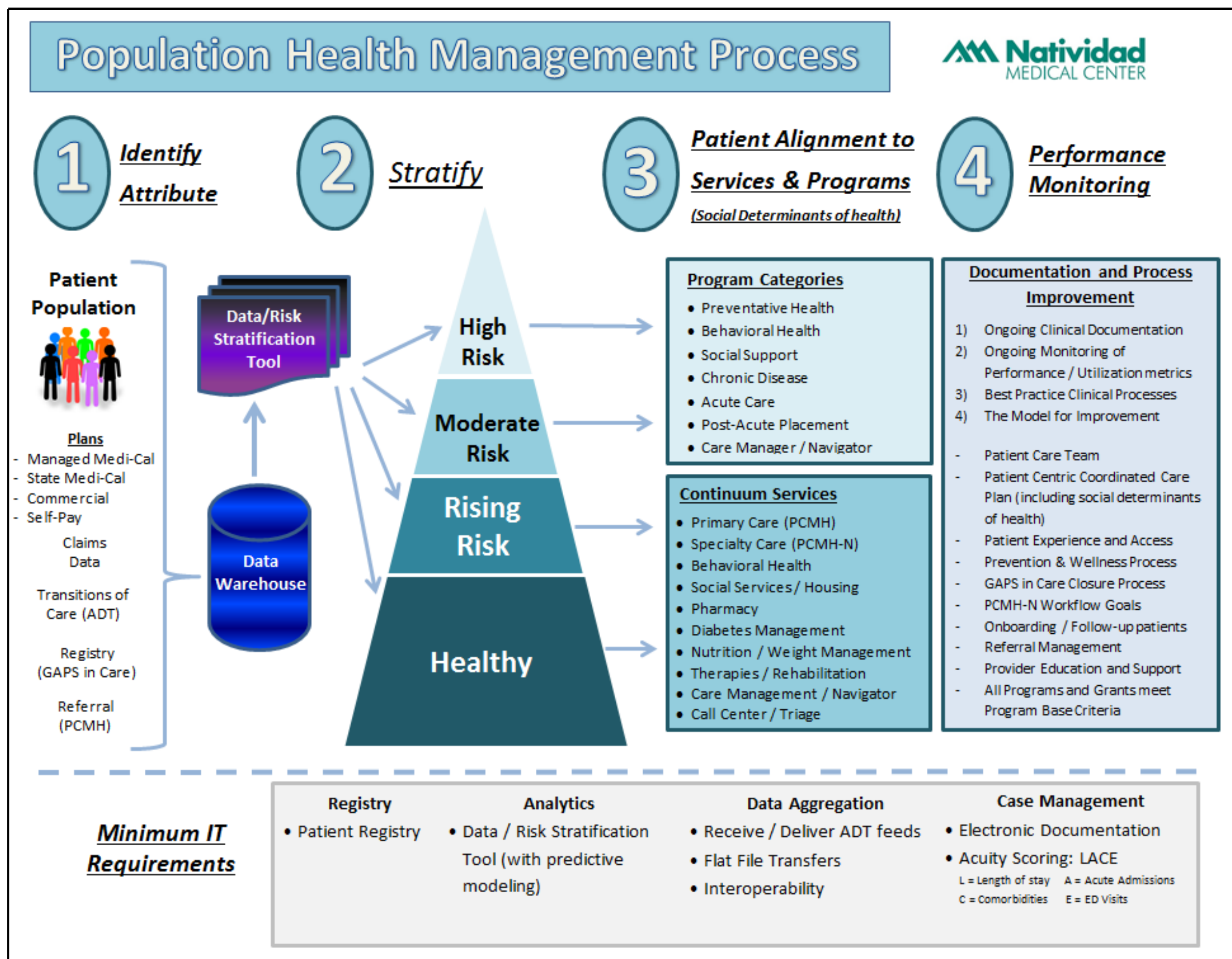

Diagram 1

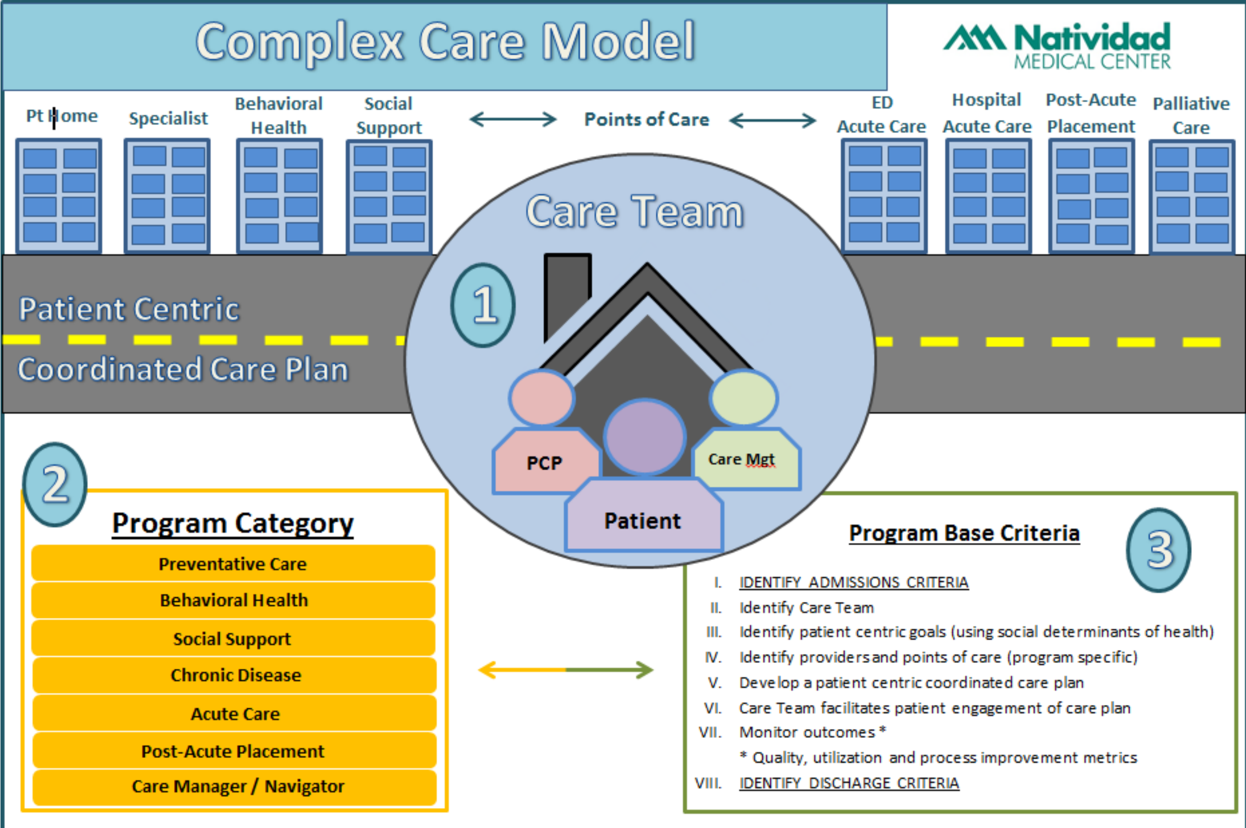

Diagram 2

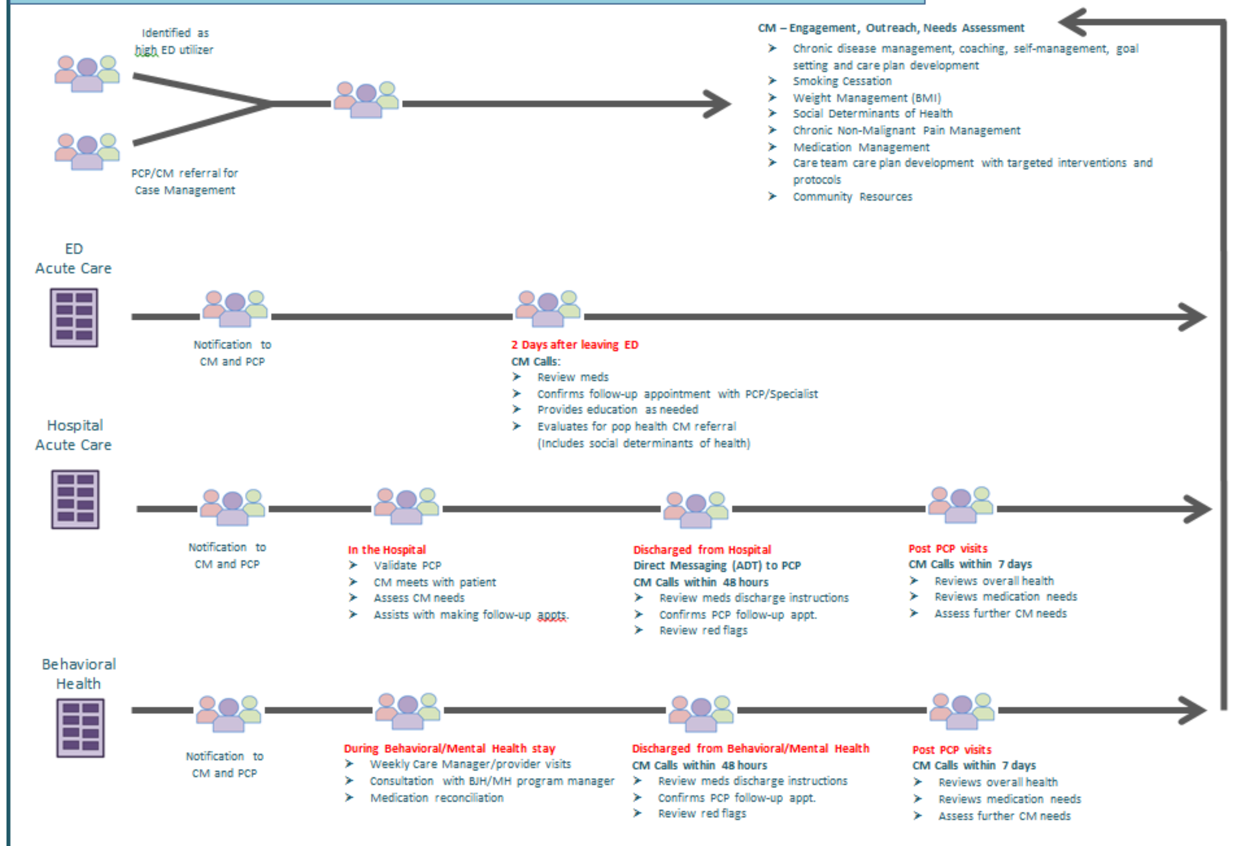

Diagram 3

Natividad MEDICAL CENTER

Population Health Model – Program Base Criteria Guide Document

Program Category	Circle One: Preventative Care Behavioral Health Social Support Chronic Disease Acute Care Post-Acute Placement Care Manager / Navigator
Program Name	*Name of program*
I. Identify Admission / Population Criteria	*List Admission Criteria for patients to participate in the proposed program. "Stratification/Attribution"* • *Also include data source, if applicable (i.e. claims data, ADT feeds, fax notifications, etc.)*
II. Identify Care Team	*Care Team to Include:* ***Required*** • ***Patient*** • ***PCP*** • ***Care Manager (Specific to Program)*** • *Other (Specific to Program)*
III. Identify Patient Centric Goals (using social determinants of health)	*Explain patient centric goals that the proposed program will help achieve.*
IV. Identify Transitions of Care Opportunities	*List Providers, Point of Care, and Transitions of Care that the patient may come in contact with.*
V. Patient Centered Coordinated Care Plan	*Develop a "Patient Centered Coordinated Care Plan" which should include:* • *Individualized patient centric goals* • *Social Determinants of Health* • *Identifiable and measurable goals*
VI. Care Team Facilitates Patient Engagement of Care Plan	*Provide details regarding patient engagement and/or notification to implement Care Plan. Also include any contract agreement details and documentation.*
VII. Monitor Outcomes (Quality, Utilization, and Process Improvement)	*List all Quality, Utilization and Process Improvement outcomes. Provide details on how to capture and report data.* • *Reporting Results: Explain the Reporting Method for each Outcome (Percentage, Volume Increase, Rate, etc.).* • *Frequency: List the reporting frequency for each outcome(s)* • *Benchmarks / Program Goal: List any benchmarks and/or program goals that much be achieved*
VIII. Identify Discharge Criteria	*List Discharge Criteria for patients to exit the program* • *Also include any notifications and / or documentation of patients that qualify for discharge (i.e. PCP notification, transition to another program)*

Diagram 4

Appendix C- References

Monterey County Health Department (2013). *Monterey County 2013 Community Health Assessment.* Retrieved from http:// www.mtyhd.org

United States Census (2016). *Quick facts Monterey County, California.* Retrieved from http:// census.gov

Primary Care Pain Medication Prescribing Guidelines Community Hospital of Monterey Peninsula

Retrieved from https://www.chomp.org/app/files/public/6226/Primary-Care-Pain-Medication-Prescribing-Guidelines.pdf