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

Application due: April 4, 2016

REVISED May 20, 2016

PIONEERS MEMORIAL HEALTHCARE DISTRICT

207 West Legion Road

Brawley, CA 92227

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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 the 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

Pioneers Memorial Healthcare District

Health Care System Designation(DPH or DMPH)

DMPH

Section 2: Organizational and Community Landscape

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

2.1 Community Background. *[No more than 400 words]*
Drawing on available data (e.g., DHCS, Office of Statewide Health Planning and Development, U.S. Census Bureau), summarize the health care needs and disparities that affect the health of your local community.

Pioneers Memorial Healthcare District (PMHD, "the District") is located in the Imperial Valley in southeastern California. Hospital and outpatient services are available in Brawley (population 25,897), and in Calexico (population 40,564)[1] on the California-Mexico border. Much of Imperial County is designated as a medically underserved area (MUA) and a health professional shortage area (HPSA) for primary care and mental health.

Physical Health. The most significant health issues facing our community include asthma, obesity/diabetes, heart disease, and hypertension:

Asthma: The prevalence of asthma among adults in Imperial County is 14%, (CA-14%).[2] Hospitalization rates for children with asthma are triple the statewide rate; similarly, the ED visit rate is double in Imperial County, compared to California.[3]

Obesity/Diabetes: Nearly 75% of Imperial County adults report being overweight or obese, which contributes to the 6% of County residents diagnosed with diabetes (CA-8%).[4] Imperial County has the highest percentage (41%) of hospitalizations for patients with diabetes in the state.[5]

Heart Disease: Nearly 7% of County residents report diagnosis of heart disease (CA-6%); of these, 18.5% have congestive heart failure (CA-30%).[6]

Hypertension: 27% of County (and California) residents report a diagnosis of high blood pressure.[7] Of these, 40% report not taking the prescribed medications for this condition.[8]

Tuberculosis: Imperial County has the highest rate of tuberculosis in California, at 16.7 cases per 100,000 population, compared to the 6.4 CA rate. An estimated 50% of these cases are binational.[9]

Behavioral Health. 9% of County residents report serious psychological distress.[10] County (and statewide) residents report an average of 4 mentally unhealthy days in

the past 30 days.[11] 23% report a lack of adequate social/emotional support.[12] 65% of Imperial County 11th graders report depression-related feelings.[13]

Health Disparities. Hispanics are twice as likely to lack a primary care provider (42%), compared to whites (18%).[14] Depression-related feelings are reported more frequently by American Indians (38%) than Hispanics (34%) or whites (26%).[15] Of the breast cancer cases in Imperial County, 77% are diagnosed in Hispanic women, compared to 17% whites.[16]

Coverage. 79% of the County population has health insurance. 42% of insured are covered by Medi-Cal (CA 23%). 39% of Imperial County's uninsured population is Hispanic.[17]

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.

The U.S.-Mexico border region is characterized by migration, poverty, and environmental challenges. If this region were a state, it would rank last on access to health care, second in hepatitis deaths, third in diabetes deaths, last in per capita income and first in number of children living in poverty and without health insurance.

While residents' health status has improved in some areas since 2002, poverty and environmental contamination continues to threaten the health of the population. Approximately 30% get health care in Mexico.

Income: Median income is $43,310.[18] Per capita income is $16,673 (CA $29,527) and 23% of residents live at or below the Federal Poverty Level (CA 16%).[19]

Race/Ethnicity/Language: 81% of the local population is Latino/Hispanic (CA 38%). An estimated 32% of County residents are of foreign birth. 51,000 residents are Spanish-speaking and have limited English proficiency; 16% identify as linguistically isolated.[20]

Age: The median age of Imperial County residents is 32 years. Breakdown: age 0 – 17: 29%, age 18-64: 60%, age 65 or older: 11%.[21]

Disability: 13% of Imperial County residents identify as disabled; 10% of these are age 18-64, 52% are age 65 and over, and 12% are Latino.[22]

Social: Most of the population in Imperial County (83%) lives in an urban setting, 17% rural.[23] 35% of residents age 25 and older do not have a high school diploma.[24] The unemployment rate is 19% (CA 6.5%).[25] 9% of households have no motor vehicle (CA 8%).[26]

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.

PMHD owns and operates Pioneers Memorial Hospital, which is a general acute care hospital in Brawley, CA. The hospital is licensed for 107 beds, has a 16-bed emergency facility that is a Level-4 trauma center, and has a medical staff of 83 providers. The hospital carries the Det Norske Veritas accreditation.

The Phyllis Dillard Family Medical Center houses the surgery center and obstetrical services. The PMHD Wound Center offers outpatient clinical wound care and hyperbaric medicine. The Cancer Institute provides chemotherapy, biotherapy, and immunotherapy services

The District also owns and operates two rural health clinics, Pioneers Health Center (in Brawley) and Calexico Health Center, both of which provide primary care and urgent care services in extended hours. Select specialty care is available including but not limited to pediatrics, general surgery, orthopedics, gastroenterology, urology and nephrology.

PMHD data (2015) reveals the following payer mix: Medi-Cal 40%, Medicare 30%, private insurance 15%, worker's compensation 5%, local prison 5%, other / uninsured 5%). Of the 40% Medi-Cal recipients, 75% are assigned to California Health and Wellness (managed care), 15% Molina Health Plan (managed care), and 10% State Medi-Cal basic coverage plan.

PMHD encounter data for 2015 shows 47,961 visits to the hospital's emergency room (9% increase). The hospital had a total of 7,401 admissions. In 2015, PMHD physicians performed 1,670 inpatient procedures (includes C-sections) and 3,061 outpatient surgeries.

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.

Consistent with the DNV accreditation requirements, PMHD's quality management program ensures continual improvement through measuring, monitoring and analyzing data. PMHD's Patient Safety and Quality Council (PSQC) routinely reviews data on selected quality and safety metrics. The Council is comprised of

various department and service line leaders, including administration and Medical Staff.

PMHD's IT department has specialists in hardware, software, data extracts, and reporting. This team works closely with the Quality Resource Department to map data and prepare performance improvement reports. PMHD anticipates hiring additional IT support, specifically to support the outpatient EHR (eClinicalWorks) for activation of functionality, staff training, and reporting.

Multiple technology applications provide data reports for both hospital and clinic environments. QCPR is the hospital's EHR. The Midas care management system is used to capture information on inpatients and will support the development of a transitional care plan. The outpatient clinics utilize eClinicalWorks. Demographics and ADT information flow into QCPR to enable information sharing between inpatient and outpatient environments. Enhancements to eClinicalWorks will support PRIME reporting for the two clinic-based projects. MedMined software was recently implemented for infection control surveillance and will support PRIME reporting for the Antimicrobial/Antibiotic Stewardship project.

Given our existing foundation with technology systems and quality/performance management, we do not anticipate any barriers to meeting the PRIME reporting requirements . Interfaces will be developed, where possible, to enable enterprise-wide electronic communications and documentation. Our analytics staff will be tasked with testing the interfaces and data flow to ensure reporting capability from the most appropriate technology resource to meet quality reporting goals, including PRIME. Additionally, staff will need training on the new care delivery concepts, as well as their changing roles as the PRIME projects get underway. For these reasons, we have included infrastructure-building process measures to assure that data validation and reporting functions are reliable, and that staff are trained, before submitting baseline data.

Section 3: Executive Summary

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

3.1 PRIME Project Abstract [No more than 600 words]

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.*

Consistent with the PMHD strategic plan, as well as Imperial County's Strategic Goals, the organization will redesign its delivery system. Organizational goals which directly align with the PRIME Initiative include:

1. Develop a clinically integrated, patient-centered, cost effective and financially viable service delivery model that is prepared for the emerging value-based reimbursement strategy through coordinated care management and integrated health information technology.

2. Adopt a framework for population health management which focuses on prevention, wellness, chronic disease management, and new care delivery models.

*2. List specific aims** for your work in PRIME that relate to achieving the stated goals;*

*Note: ** Specific aims (generally 2-5) relate to the goals but provide more detail on how the goals will be achieved,*

Through the PRIME initiative, PMHD aims to:

1. Identify and target high risk populations, improve patients' self-care capabilities, and optimize patients' course of chronic illness

2. Ensure coordinated delivery of services and continuity of care, effectively transferring health care responsibility to the appropriate health care resource

3. Inspire judicious use of antimicrobials

4. Improve health outcomes, efficiency in care delivery, and patients' experience of care, and

5. Prevent avoidable ED utilization and hospitalization.

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

PMHD has selected four PRIME projects: 1.4 Patient Safety in the Ambulatory Setting; 1.6 Prevention-Cancer Screening; 2.2 Care Transitions-Integration of Post-Acute Care; and 3.1 Antibiotic Stewardship. These projects will act as a catalyst to drive clinical integration between the inpatient and outpatient environments, establishing proactive communication through new strategies and IT adjuncts along the continuum to ensure: 1) coordination of care, 2) management and follow-up of patient results, 3) stewardship of healthcare resources and 4) strategies that engage patients, the community and the healthcare system in changes that will result in effective and efficient systems of care.

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

The development of a Care Transitions Program will result in a complementary outpatient component to accept handoffs of patients as they exit the hospital and resume care in the primary care setting. The Nurse Care Coordinator in the clinic will be involved in both the Cancer Screening and Patient Safety initiatives. As the Care Transitions team provides education and support to patients upon discharge, the clinic team will be prepared to receive the patients back into the clinic setting.

The Antimicrobial Stewardship team will engage the PMHD clinics as protocols for antimicrobial use are developed. The PRIME clinician champion will ensure training of the providers and clinical staff to raise awareness of proper use of antibiotics and appropriate messaging for patients to stem the overuse of these medications.

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.

PMHD anticipates broad-reaching impact spanning enhanced patient experience (through integrated care and patient-centered touchpoints), improved clinical outcomes (through motivational interviewing and enhanced patient engagement), and reduced cost of health care by eliminating duplicate testing, reducing inappropriate antimicrobial use, and preventing avoidable ED utilization and/or hospitalization.

Care management staff will become adept at engaging patients in optimal self-care and providing linkages to community-based organizations. Transitions of care will be seamless; patients will actively engage in healthcare decision-making and become more confident in caring for their health conditions in the home and community setting. Access to primary and specialty care will be enhanced, and the Nurse Care Coordinators will become trusted partners to the primary care teams. Care management services will generate a new revenue stream.

PMHD clinicians will make informed choices about use of antibiotics, and will strive to preserve the health of the community through infection control surveillance methodology and appropriate prescribing practices.

Interfaced technology systems will eliminate duplicate data entry, enable documentation of health events, and facilitate quality reporting. A population health management approach will feed the quality improvement agenda with data upon which to make decisions about interventions to improve workflows for efficiency and concomitantly improve clinical outcomes.

PMHD envisions a transformed delivery system through its integrated health service programs. PMHD will become the provider of choice and will be recognized as the healthcare anchor in the Imperial Valley communities.

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.

Through the Care Transitions Program, PMHD will expand its hospital-based care management services with a focus on patients at high risk for readmission. The team will target conditions of high prevalence in the PMHD service area, including but not limited to asthma, diabetes and heart disease. Patients will benefit from individualized support aimed at improving confidence in self-care. We also anticipate reduction in avoidable emergency department visits and hospitalizations for high-risk conditions.

Hispanic women have a disproportionate incidence of breast cancer in Imperial County. Conducting targeted outreach to individuals with known gaps in care will promote understanding of screening guidelines and encourage screening at recommended intervals. Early cancer detection yields the best survival rates.

Local data reveals a high incidence of heart disease in Imperial County. Participation in the Patient Safety initiative will help raise patient awareness about the importance of laboratory surveillance of patients on long-term medications. Embedded decision support in the EHR system will ensure that patients receive the right complement of services at the right time.

Addressing antibiotic resistance through an Antimicrobial Stewardship Program will ensure patients receive the right antibiotic, at the right time, in the right amount and for the right duration. Targeting bacteria with specific drugs will potentially lower cost, enhance effectiveness and mitigate resistance. The use of a regional antibiogram will be an effective tool in educating providers regarding prescribing specificity of appropriate antibiotics for the region.

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).*

The PMHD CFO is our PRIME executive champion and leads the PRIME Steering Committee. As a senior executive, the CFO attends all leadership meetings and board meetings, and will keep the executive team apprised of progress and issues needing resolution to ensure success.

The PRIME Steering Committee has approved a charter to guide and oversee the work of the individual PRIME projects. Project subcommittees have initiated the five-year planning towards a set of common goals. Action steps have been implemented to set the stage for HIT enhancements, human resources planning, and community partnership development.

Each year, PMHD selects a large scale project that interweaves multiple departments in a system transformation effort. All projects under the PRIME Initiative have been adopted by PMHD as its annual quality improvement projects. This selection by the District leadership ensures that the projects will be properly resourced with staff, time and technology to ensure success and sustainability. The PRIME Steering Committee has developed a PRIME 5-year resource/budget plan, which is now under executive review.

In 2015, PMHD established an Antimicrobial Stewardship Program Committee which examines local microorganisms and antibiotic use/over-use. This committee will

serve as the design, implementation and management body for the Antimicrobial Stewardship initiative under PRIME.

The Quality Improvement team has prepared a matrix of PRIME metrics, including those required by the State and those selected by the project teams as milestones and measurable process metrics. Problem-solving efforts are underway to determine data sources and strategies to automate data capture. An executive dashboard has been created to enable the PMHD Administrative team to follow progress and report to the Board of Directors on a regular basis.

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.

The District's monthly Governing Board Meetings are open to the public. Progress reports on the PRIME initiative will be presented by the District Administrators and PRIME Project Leaders. Public comment is invited; relevant comments will be relayed to the PRIME Steering Committee.

Focus groups, in English and Spanish, will be used to engage the community for service planning and improvement. PMHD has a strong presence at community events, including the Farmer's Market, the County Fair, and community health fairs. These activities engage patients/community members in dialog about health care and encourage them to participate in our service planning efforts.

The Care Management team conducts post-discharge interviews with patients to ascertain their satisfaction with care received in the hospital, as well as preparation for returning to the home environment. Results from these brief surveys are aggregated and used in service planning.

The Antimicrobial/Antibiotic Stewardship Committee is co-chaired by the only Infectious Disease and Intensivist Physicians in the County. The Committee has engaged the El Centro Regional Medical Center Antimicrobial Stewardship team in collaboration to share standardized policies, progress towards goals, and emerging best practices.

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 District is committed to ensuring that the needs of our diverse patient population are met, including linguistic and cultural competency. The majority of PMHD employees are bilingual and bicultural, reflecting the community we serve. While most of our staff are homegrown and continue to serve the community, PMHD provides cultural competency training to promote health and decrease disparities. The Care Transitions Program Nurse is bilingual in Spanish and comes from the local community.

Print materials for eligibility/enrollment are available in English and Spanish (our identified threshold languages), as are health educational materials. PMHD provides real-time access to interpreter services in the patients' language of choice using Language Line Solutions. The service not only provides language services but also uses Skype to ensure visual cues of understanding or misunderstanding are not missed.

Through PRIME, PMHD will embark on a population health management approach to serve all projects – Care Transitions, Patient Safety, Prevention/Cancer Screening, Antimicrobial Stewardship. This will enable our clinical teams to evaluate data with an eye for health care disparities amongst the populations we serve. Our tools for reducing/eliminating disparities, when identified, include deep cultural knowledge, language capability, and translated materials.

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.

The full engagement of the PMHD leadership team and Board of Directors will ensure that gains made during the PRIME initiative are sustained. Clinician champions will apply their leadership to program implementation and future replication of the PRIME initiative to other clinics, and also applied to other subject matter. Reimbursable care management services will provide a new revenue stream, which will help us sustain staffing and operational changes made through the PRIME transformation initiatives.

Skills in quality improvement methodologies, such as rapid cycle improvement and population health management, will be honed during the PRIME initiative. These skills will provide a foundation for health system transformation, and will prepare us for successful participation in the evolving value-based reimbursement structure beyond PRIME participation.

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 the *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 approach to implementation.

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

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

- Select at least four projects from Domain 1 (Projects1.1, 1.2, and 1.3 are required);
- Select at least four projects from Domain 2 (Projects 2.1, 2.2, and 2.3 are required); and,
- Select at least one project from Domain 3.

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

Instructions: For sections 4.1-4.3 click the box(es) that correspond to the project(s) you will undertake. In addition, click the boxes that correspond to the core components you will undertake 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 only (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

☒ 1.4 – Patient Safety in the Ambulatory Setting

Rationale

The chronic disease burden in Imperial County is significant, with 34% of the population reporting one chronic disease, 7% reporting two, and 2% reporting three to five chronic diseases.[27] These conditions result in a high degree of health care resource utilization, from primary care clinic, specialist, ED and hospital, and beyond. Medication management becomes increasingly complex as the condition advances and/or as co-morbidities develop.

Patient safety often pivots on medication management, but is also compromised when clinical and laboratory surveillance is suboptimal for patients taking long-term medications. Protocols are needed to ensure that laboratory values are reportedly timely and that proper clinical follow-up is initiated.

Implementation Plans

The Calexico Health Center Medical Director is the clinician champion for this project. In collaboration with the Pioneers Health Center Medical Director, and supported by the respective clinic managers, she will lead the clinical teams through the adoption of new evidence-based protocols for required laboratory surveillance for patients on long-term ACE/ARB, digoxin, diuretics and Warfarin. Clinic staff will be trained on the protocols.

The District's rural health clinics will utilize eClinicalWorks EHR to document clinical events, capture discrete data, and pull relevant reports to support population health management as required by this project. Preliminary work is underway to ensure that the EHR's embedded decision support is functional and activated.

The clinic teams will be trained on population health management methodology. New workflows will be adopted to ensure that patients receive the right care at the right time. When gaps in care are identified, targeted outreach will be done to bring the patients in for the needed services.

In DY13, the initiative will be spread to the Pioneers Health Center. Throughout the five-year timeline, PMHD will prepare comparative reports to show progress on all metrics for both health centers.

PMHD's complete 5-year workplan is included as Appendix 3. As the project evolves, the workplan is subject to modification.

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

The target population includes all patients over 18 years who are taking medications which require routine laboratory surveillance. For this PRIME project, the medications include ACE/ARBs, digoxin, diuretics, and warfarin.

This project will improve the staff's understanding of medications prescribed, importance of medication monitoring, as well as clinical signs and symptoms for conditions of focus. With greater understanding of the clinical need for laboratory surveillance for these patients, our staff will ensure that patients receive the needed services. PMHD currently utilizes multiple community laboratories, one of which is hospital-based. Our existing protocol for reporting critical lab values does not address processes for external laboratories. In addition, there is no formal process for reporting abnormal values. Focusing on this element will improve our workflows for test results processing, to include normal and abnormal test results as well as critical values.

Enhancements to the EHR system will be utilized to provide "alerts", allowing the clinical team members to establish laboratory requisitions through standing orders.

Skills learned in population health management will allow the clinical teams to apply this approach to other populations in the future, thereby expanding the reach of the quality/safety improvement focus.

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

Check, if applicable	Description of Core Components
Applicable	**1.4.1** Perform a baseline studies to examine the current workflows for abnormal results follow-up and monitoring of individuals on persistent medications.
Applicable	**1.4.2** Implement a data-driven system for rapid cycle improvement and performance feedback based on the baseline study that effectively addresses all identified gaps in care and which targets clinically significant improvement in care. The improvement and performance feedback system should include patients, front line staff from testing disciplines (such as, but not limited to, radiology and laboratory medicine) and ordering disciplines (such as primary care) and senior leadership.
Applicable	**1.4.3** Develop a standardized workflow so that: • Documentation in the medical record that the targeted test results were reviewed by the ordering clinician. • Use the American College of Radiology's Actionable Findings Workgroup[1] for guidance on mammography results notification. • Evidence that every abnormal result had appropriate and timely follow-up. Documentation that all related treatment and other appropriate services were provided in a timely fashion as well as clinical outcomes documented.
Applicable	**1.4.4** In support of the standard protocols referenced in #2: • Create and disseminate guidelines for critical abnormal result levels. • Creation of protocol for provider notification, then patient notification. • Script notification to assure patient returns for follow up. Create follow-up protocols for difficult to reach patients.
Applicable	**1.4.5** Implement technology-enabled data systems to support the improvement and performance feedback system as well as engage patients and support care teams with patient identification, pre-visit planning, point of care delivery, and population/panel management activities.

☒ 1.6 – Cancer Screening and Follow-up

Rationale

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

Imperial County rates for cancer screening are lower than for California, indicating a need for a strong focus on these important services for PMHD patients. The breast cancer screening rate in Imperial County is 46%, compared to 59% statewide. Imperial County and California cervical cancer screening rates are nearly identical (77% vs. 78% respectively).[28] Colorectal cancer screening in Imperial County is 50%, compared to 58% statewide.[29] As noted earlier, there is a significant disparity in breast cancer prevalence among Hispanic women in Imperial County.

Implementation Plan

The Calexico Health Center Medical Director will be the Clinician Champion for this project. Working collaboratively with the Pioneers Health Center Medical Director, and supported by the respective clinic managers, evidence-based guidelines will be adopted for the cancer screenings, and workflows will be modified to ensure relevant data is captured routinely. EHR system enhancements are currently underway to enable "alerts" to allow the clinic team to prepare test requisitions and referrals under standing orders.

The clinic teams will be trained on population health management methodology and new workflows will be adopted to ensure that patients receive the right care at the right time. When gaps in care are identified, targeted outreach will be done to bring the patients in for the needed services.

When the processes have been refined, the initiative will be spread to the Pioneers Health Center. As the initiative proceeds through the five-year timeline, PMHD will prepare comparative reports to show progress on all metrics for both health centers.

PMHD's complete 5-year workplan is included as Appendix 4. As the project evolves, the workplan is subject to modification.

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

In general, women between the ages of 50 and 74 will receive annual breast cancer screening; women between the ages of 24 and 64 will receive cervical cancer screening, and individuals between the ages of 50 and 75 will receive colorectal cancer screenings. Additionally, women with a screening/diagnostic mammogram BIRAD Score of 4 or 5 will require additional diagnostics. Exceptions and exclusions will be applied to each screening protocol, as recommended by the US Preventive Services Task Force.

This project will improve the staff's understanding of cancer prevalence and the importance of screening tests. With greater understanding of the clinical need for screening, our staff will ensure that patients are educated on screening tests and receive the needed services.

Enhancements to the EHR system will be utilized to provide “alerts”, allowing the clinical team members to prepare laboratory requisitions and referral requests through standing orders.

Skills learned in population health management will allow the clinical teams to apply this approach to other populations in the future, thereby expanding the reach of the quality/safety improvement focus.

3. *Infrastructure-building Process Measures* – Yes, see Appendix 2.

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

Check, if applicable	Description of Core Components
Applicable	**1.6.1** Develop a multi-disciplinary cross-participating PRIME entity task force to identify principle-based expected practices for screening and follow-up for the targeted services including, but not limited to: • Standard approach to screening and follow-up within each DPH/DMPH. • Screening: o Enterprise-wide standard approach to screening (e.g., ages, frequency, diagnostic tool). • Follow-up for abnormal screening exams: o Clinical risk-stratified screening process (e.g., family history, red flags). Timeliness (specific time benchmark for time from abnormal screening exam to diagnostic exam).
Applicable	**1.6.2** Demonstrate patient engagement in the design and implementation of programs.
Applicable	**1.6.3** Collect or use preexisting baseline data on receipt and use of targeted preventive services, including any associated disparities related to race, ethnicity or language need.
Applicable	**1.6.4** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to USPSTF A and B Recommendations.
Applicable	**1.6.5** Improve access to quality care and decrease disparities in the delivery of preventive services.

Check, if applicable	Description of Core Components
Applicable	**1.6.6** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
Applicable	**1.6.7** Adopt and use certified electronic health record systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population management approaches (e.g., in-reach, outreach) to reduce gaps in receipt of care.
Applicable	**1.6.8** Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.
Applicable	**1.6.9** Implement a system for continual performance management and rapid cycle improvement that includes feedback from patients, community partners, front line staff, and senior leadership.

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):		**2**
Domain 1 Total # of Projects:		**2**

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

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

Rationale

Documented health indicators and a high readmissions rate led PMHD to develop a Care Transitions Program (CTP). Additional support along the continuum of care is necessary to optimize health outcomes, ensure appropriate health resource utilization, and reduce readmissions.

PMHD data for Q22014-Q12015 showed 1,388 discharges and 236 readmissions within 30 days; source of readmission was 22% SNF, 18% home, and 18% home health care. 46% of patient discharges in 2015 were Medi-Cal recipients.

PMHD desires to stabilize the transfer and referral process through a structured care management approach in order to avoid early discharges, promote patient self-care and management, and avoid readmissions.

Implementation Plan

PMHD's Care Transitions Program will be led by a Care Transitions Nurse. A pre-admission risk assessment will rate the patient's readmission potential. Pre-discharge dialog with patients/families will provide education and support to enable self-management at home.

As patients leave the ED/hospital, the CTP team will encourage follow-up through local primary care providers. Patients lacking a designated primary care provider will be assigned to PMHD's primary care clinics. A clinic-based Nurse Care Coordinator will provide patient education and follow-up, with a goal of empowering patients towards better self-care and improved clinical outcomes.

Community relationships will be enhanced to expand available services. Care Managers will refine referral mechanisms to coordinate care with healthcare partners who currently include three skilled nursing facilities, home health care, hospice care, and adult day health centers.

The Midas care management system will be utilized for care management documentation in the hospital setting, including the transitional care plan. The Midas robust reporting module will enable PMHD to capture many dimensions of data relevant to admissions and readmissions.

PMHD's complete 5-year workplan is included as Appendix 5. As the project evolves, the workplan is subject to modification.

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

The target population includes patients who have been discharged from the hospital. Patients will be assessed using an evidence-based tool to identify individuals with a high risk for readmission. Medi-Cal eligible patients at high risk for readmission will be a primary focus to facilitate appropriate and timely post-discharge follow-up and referral community resources.

PMHD will transform its system of care to improve access to primary care, focus on population health management, and promote patient safety as patients move from one health care entity to another. New skills in care management will result in better care coordination, improved team communications, and more appropriate use of health care resources.

Through the readmission risk assessment score, the CTP team can take extra steps to prepare the patient/family for discharge. The team will develop an individualized discharge plan, and conduct a simulation experience of self-care activities prior to discharge. This will ensure that patients are able to successfully manage all aspects of self-care.

Liaison to the PMHD outpatient clinics will create a strong continuum of support for patients as they transition back to primary care. A trained Nurse Care Coordinator will follow-up with patients shortly after discharge to ascertain the patient's current health status and level of understanding about follow-up care and identify barriers to successful self-management.

Enhanced communications between the CTP team and community care partners will strengthen referral mechanisms to ensure seamless transition to downstream providers. This strategy reinforces our commitment to serving the PMHD patient population along the continuum of care.

3. *Infrastructure-building Process Measures* – Yes, see Appendix 2.

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.

Check, if applicable	Description of Core Components
Applicable	**2.2.2** Establish or expand on a system to track and report readmission rates, timeliness of discharge summaries, and other transition processes, and investigate system-specific root causes/risk factors for readmission, using quantitative and qualitative information to identify the key causes of readmissions, including physical, behavioral and social factors.
Applicable	**2.2.3** Develop and implement a process, including utilization of data and information technology, to reliably identify hospitalized patients at high-risk for readmission.
Applicable	**2.2.4** Develop standardized workflows for inpatient discharge care: • Optimize hospital discharge planning and medication management for all hospitalized patients. • Implement structure for obtaining best possible medication history and for assessing medication reconciliation accuracy. • Develop and use standardized process for transitioning patients to sub-acute and long term care facilities. • Provide tiered, multi-disciplinary interventions according to level of risk: o Involve mental health, substance use, pharmacy and palliative care when possible. o Involve trained, enhanced IHSS workers when possible. o Develop standardized protocols for referral to and coordination with community behavioral health and social services (e.g., visiting nurses, home care services, housing, food, clothing and social support). Identify and train personnel to function as care navigators for carrying out these functions.
Applicable	**2.2.5** Inpatient and outpatient teams will collaboratively develop standardized transition workflows: • Develop mechanisms to support patients in establishing primary care for those without prior primary care affiliation. Develop process for warm hand-off from hospital to outpatient provider, including assignment of responsibility for follow-up of labs or studies still pending at the time of discharge.
Applicable	**2.2.6** Develop standardized workflows for post-discharge (outpatient) care: • Deliver timely access to primary and/or specialty care following a hospitalization. • Standardize post-hospital visits and include outpatient medication reconciliation.

Check, if applicable	Description of Core Components
Applicable	**2.2.7** Support patients and family caregivers in becoming more comfortable, competent and confident in self-management skills required after an acute hospitalization by providing: • Engagement of patients in the care planning process. • Pre-discharge patient and caregiver education and coaching. • Written transition care plan for patient and caregiver. • Timely communication and coordination with receiving practitioner. Community-based support for the patient and caregiver post hospitalization focusing on self-care requirements and follow-up care with primary and specialty care providers.
Applicable	**2.2.8** Engage with local health plans to develop transition of care protocols that ensure: coordination of care across physical health, substance use disorder and mental health spectrum will be supported; identification of and follow-up engagement with PCP is established; covered services including durable medical equipment (DME) will be readily available; and, a payment strategy for the transition of care services is in place.
Applicable	**2.2.9** Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**2.2.10** Increase multidisciplinary team engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on care model.
Applicable	**2.2.11** Implement a system for continual performance feedback and rapid cycle improvement that uses standard process improvement methodology and that includes patients, front line staff and senior leadership.

Please complete the summary chart:

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

Section 4.3 – Domain 3: Resource Utilization Efficiency

☒ 3.1 – Antibiotic Stewardship

Rationale

Timely selection and administration of appropriate antimicrobial therapy can significantly impact treatment outcomes, both with surgical prevention and in patients with severe or life-threatening infections. Appropriate use of antimicrobials has the potential to improve efficacy, reduce cost, minimize drug-related adverse events, and limit the potential for emergency or antimicrobial resistance.

Following the California Antimicrobial Stewardship Program Initiative, PMHD's pharmacy director initiated an Antimicrobial Stewardship Program (ASP), with a local infectious disease expert co-leading efforts in 2015. With the highest tuberculosis incidence in California, Imperial County health leaders are collaborating with Mexican health officials on a binational TB control strategy. PMHD's ASP will follow their progress and benefit from their knowledge on this issue.

This PRIME initiative provides an opportunity and additional guidance to examine the local antibiogram, develop protocols for antimicrobial use, and educate area providers about the community impact of appropriate antimicrobial use.

Implementation Plan

The ASP Committee will guide the design and implementation of this initiative. Committee membership has been expanded to include the infection control nurse and laboratory/microbiology representative. Collaboration with El Centro Regional Medical Center's ASP team has begun.

Policies and procedures will be reviewed, and created as needed. Evidence-based clinical practice guidelines for laboratory testing and antibiotic selection will be formally adopted. CPOE algorithms will be developed for duration, switching and restricting the use of antibiotics. An antibiotic formulary will be developed based on the local antibiogram. Providers and clinical staff will be trained on new protocols.

MedMined software application will enable reporting on PRIME metrics, allowing the ASP team to follow antimicrobial use and understand physician prescribing patterns. This data will help PMHD refine its ASP program and target educational efforts most effectively.

PMHD's complete 5-year workplan is included as Appendix 6. As the project evolves, the workplan is subject to modification.

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

The target population for the PMHD Antimicrobial Stewardship Program includes all patients with at least two primary care encounters and all patients with any acute care utilization during the measurement year, for patients 18 years or older, except when stipulated by NHSN to include pediatric populations.

The PRIME project will help us strengthen our existing antibiotic stewardship program. Altering provider prescribing patterns using evidence-based guidelines and introduction of the community antibiogram will have an impact on efficiency and effectiveness of clinical therapy, improved response to infection, as well as cost of care. Launching a clinic-based educational campaign will improve patient understanding of proper use of antibiotics, which will alleviate pressure on providers to prescribe unnecessarily.

With the US-Mexico border in close proximity, the controls on access and cost of prescription antibiotics is lessened, all facilitating the imprudent use of antibiotics. The ASP will incorporate community education to facilitate a reduction of inappropriate antibiotic use from across the border. With judicious use of antibiotics and community understanding, a decrease in multidrug resistant organisms and healthcare associated infections should be realized.

3. *Infrastructure-building Process Measures* – Yes, see Appendix 2.

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

Check, if applicable	Description of Core Components
Applicable	**3.1.1** Utilize state and/or national resources to develop and implement an antibiotic stewardship program, such as the California Antimicrobial Stewardship Program Initiative, or the IHI-CDC 2012 Update "Antibiotic Stewardship Driver Diagram and Change Package.[2] • Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**3.1.2** Develop antimicrobial stewardship policies and procedures.

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

Check, if applicable	Description of Core Components
Applicable	**3.1.3** Participate in a learning collaborative or other program to share learnings, such as the “Spotlight on Antimicrobial Stewardship" programs offered by the California Antimicrobial Stewardship Program Initiative.[3]
Applicable	**3.1.4** Create standardized protocols for ordering and obtaining cultures and other diagnostic tests prior to initiating antibiotics.
Applicable	**3.1.5** Develop a method for informing clinicians about unnecessary combinations of antibiotics.
Applicable	**3.1.6** Based on published evidence, reduce total antimicrobial Days of Therapy (DOT) by providing standards and algorithms for recommended agents by disease type, focusing on short course regimens (e.g., 3-5 days of therapy for uncomplicated cystitis, 7 days for uncomplicated pyelonephritis, 5-7 days for uncomplicated non-diabetic cellulitis, 5-day therapy for community acquired pneumonia (CAP), 7-8 days for therapy for VAP or hospital acquired pneumonia).
Applicable	**3.1.7** Develop evidence-based computerized provider order entry (CPOE) algorithms and associated clinician training, to support antibiotic stewardship choices during order entry. These could include approaches such as guidelines for duration of antibiotics, within drug class auto-switching for specific antibiotics and doses, or restriction of specific antibiotics at the point of ordering (e.g., broad spectrum agents).
Applicable	**3.1.8** Implement stewardship rounds focusing on high yield drugs to promote de-escalation after the drugs are started, such as regular antibiotic rounds in the ICU.
Applicable	**3.1.9** Improve diagnostic and de-escalation processes to reduce unnecessary antibiotic use based upon length of therapy or antibiotic spectrum, such as: • Procalcitonin as an antibiotic decision aid. • Timely step-down to oral antibiotic therapy to support early discharge from the hospital for acute infections. • Use of oral antibiotics for osteomyelitis to reduce prolonged IV exposures.
Applicable	**3.1.10** Evaluate the use of new diagnostic technologies for rapid delineation between viral and bacterial causes of common infections.

[3] Launched in February 2010, this statewide antimicrobial stewardship program expands use of evidenced-based guidelines to prevent and control infections and improve patient outcomes:

Check, if applicable	Description of Core Components
Applicable	**3.1.11** Adopt the recently described "public commitment" strategy in outpatient clinics to encourage providers not to prescribe antibiotics for upper respiratory tract infections (URIs).
Applicable	**3.1.12** Publish organization-wide provider level antibiotic prescribing dashboards with comparison to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.
Applicable	**3.1.13** Implement a system a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

Please complete the summary chart:

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

Section 5: Project Metrics and Reporting Requirements

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

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

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

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

Section 6: Data Integrity

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

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

Section 7: Learning Collaborative Participation

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

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

Section 8: Program Incentive Payment Amount

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

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

- DY 11 $ 6,160,000
- DY 12 $ 6,160,000
- DY 13 $ 6,160,000
- DY 14 $ 5,544,000
- DY 15 $ 4,712,400

Total 5-year prime plan incentive amount: $ 28,736,400

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 1. References

1. State of California, Department of Finance, E4 Population Estimates for Cities, Counties and the State, 2001-2010, with Census, Sacramento CA, September 2011
2. Imperial County Public Health Status Report, 2015
3. Ibid.
4. California Healthcare Almanac, California Health Care Foundation, April 2015
5. LA Times 3-31-16, Study of CA hospitals shows a third of patients have diabetes
6. California Healthcare Almanac, California Health Care Foundation, April 2015
7. Ibid.
8. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2011-12
9. Imperial County Comprehensive Economic Development Strategy, 2014-2015 Update
10. California Healthcare Almanac, California Health Care Foundation, April 2015
11. US Census Bureau, American Community Survey, 2009-13
12. Ibid.
13. Lucille Packard Foundation for Children's Health, kidsdata.org, accessed 3-30-16
14. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2011-12
15. Lucille Packard Foundation for Children's Health, kidsdata.org, accessed 3-30-16
16. National Center for Health Statistics, 2008
17. US Census Bureau, Small Area Health Insurance Estimates, 2013
18. Imperial County Public Health Status Report, 2015
19. US Census Bureau, American Community Survey, 2009-13
20. Ibid.
21. Imperial County Public Health Status Report, 2015
22. US Census Bureau, American Community Survey, 2009-13
23. US Census Bureau, Decennial Census, 2010
24. US Census Bureau, American Community Survey, 2009-13
25. Imperial County Public Health Status Report, 2015
26. US Census Bureau, American Community Survey, 2009-13
27. California Healthcare Almanac, California Health Care Foundation, April 2015
28. Dartmouth College Institute for Health Policy Clinical Practice, Dartmouth Atlas of Health Care, 2012
29. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, US Dept of Health and Human Services, Health Indicators Warehouse, 2006-12

Appendix 2. Infrastructure Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
1.	Develop a process for timely patient notification and appropriate follow-up of abnormal and normal 1) test results, 2) screening mammograms, 3) pap smears 4) colonoscopies	• Review evidence based guidelines and develop standard protocols for patients on long term medications and cancer screening. • Review and revise current policy and procedures. • Create workflows: a) ordering tests or screening exams, b) processing test results, including normal and abnormal and critical values, c) notifying provider of result, d) notifying patient of results, e) documenting notifications, f) scheduling and documenting appropriate follow up for abnormal results. • Create training module for staff for using protocols and workflows. • Train staff on protocols and workflows. • Implement protocols and workflows. • Evaluate eCW's (EMR vendor) current capabilities to create data fields (i.e. patient notification of test results, BiRAD to Biopsy) and reports capture baseline data and to monitor staff adherence to processes, protocols and workflows. • Train staff to use eCW screening tools, alerts and notifications. • Prepare standard reports to identify gaps in care and support outreach to patients.	1.4 Patient Safety in the Ambulatory Setting 1.6 Prevention: Cancer Screening	July 2016 – June 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
2.	Establish a Transition of Care Program	• Review evidence based Transition of Care programs and select program to initiate. • Establish an inpatient and outpatient Clinical Physician Champion. • Staff training for Transition of Care Model • Create job descriptions for Transition of Care staff. Create a data base to collect qualitative and quantitative data for reporting.	2.2 Care Transitions: Integration of Post-Acute Care	July 2016 – June 2017
3.	Development of follow up process and procedures	• Review literature on care transitions best practices. • Review gaps in existing care transition process. • Based on gaps in process, develop transitions workflows in collaboration with primary care teams. • Develop training materials on new process. • Train staff on new process. • Pilot new care traction process, and make changes where necessary. Implement revised care transitions process.	2.2 Care Transitions: Integration of Post-Acute Care	July 2016 – June 2017
4.	Identification of patients at risk for readmission	• Review and pilot evidence based readmission risk assessment • Develop workflow for readmission risk assessment to utilization. • Train staff to use readmission risk assessment. • Implement readmission risk assessment.	2.2 Care Transitions: Integration of Post-Acute Care	July 2016 – June 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		Develop database to document key causes of readmission including physical, behavioral and social factors.		
5.	Improve Discharge Process using data system	• Enhancements to PMHD data systems completed to support the Care Transitions Program, to include: o Template for Transitional Care Plan o Platform for electronic notification of PCPs • Protocols developed for new Discharge Process • Care Management teams trained on use of new PMHD system processes •	2.2 Care Transitions: Integration of Post-Acute Care	July 2016 – June 2017
6.	Establish an Antibiotic Stewardship Program	• Contract with physician champion. • Establish multidisciplinary team. • Approve Antimicrobial Stewardship Program. • Complete gap analysis or other proactive assessment to identify gaps and establish Program priorities. • Develop ASP policy and procedures.	3.1 Antibiotic/ Antimicrobial Stewardship	July 2016 – June 2017
7.	Develop protocol to reduce antimicrobial Days of Therapy	• Review best practices to reduce antimicrobial Days of Therapy (DOT). • Assess gaps in existing process to reduce antimicrobial DOT. • Based on gaps identified, develop protocol to reduce antimicrobial DOT. • Train staff on to reduction of antimicrobial DOT protocol. • Pilot reduction of antimicrobial DOT protocol and make changes if necessary.	3.1 Antibiotic/ Antimicrobial Stewardship	July 2016 – June 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Implement standards for antibiotic use to reduce total antimicrobial DOT. • Explore vender capability of capturing DOT data for reporting.		
8.	Develop and implement evidence based order sets, protocol and algorithms to support the Antimicrobial Stewardship program	• Research evidence based order sets compatible with current inpatient and outpatient eMR systems. • Review current eMR capabilities using clinical decision support for appropriate antibiotic and dose. • Antimicrobial formulary developed. • CPOE algorithm created to restrict specific antibiotics at point of ordering. • • Evidence-based protocols developed for ordering laboratory specimen culture before administration of antibiotics. • Clinical staff trained on new protocols	3.1 Antibiotic/ Antimicrobial Stewardship	July 2016 – June 2017
9.	Develop and implement protocol for De-escalation of Antimicrobial Therapy.	• Review best practices in de-escalation of antimicrobial therapy. • Assess gaps in existing de-escalation of antimicrobial therapy process • Based on gaps identified, develop de-escalation of antimicrobial therapy protocol. • Develop training material for de-escalation of antimicrobial therapy protocol. • Train staff on de-escalation of antimicrobial therapy protocol. • Pilot de-escalation of antimicrobial therapy protocol and make changes if necessary.	3.1 Antibiotic/ Antimicrobial Stewardship	July 2016 – June 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		o Implement protocol for de-escalation of antimicrobial therapy.		
10.	Create and implement education program for appropriate antibiotic use	• Provide education to community providers for appropriate antibiotic use. • Provide clinical staff training about appropriate antibiotic use. o Create provider level dashboard for monitoring and measuring antibiotic use.	3.1 Antibiotic/ Antimicrobial Stewardship	July 2016 – June 2017
11.	Create and implement community outreach to improve healthcare outcomes	• Protocol developed and adopted to assist patients with use of patient portal to access medical information • Clinical staff trained to assist patients in establishing patient portal access during inpatient and outpatient visits. • Community outreach plan developed, with timeline, to include staff resources, outreach modalities and community events • Topics selected for targeted community education. o o Protocol developed for implementation of focus groups to obtain feedback regarding the effectiveness of community outreach programs, including calendar of focus group events	1.4 Patient Safety in the Ambulatory Setting 1.6 Prevention: Cancer Screening 2.2 Care Transitions: Integration of Post-Acute Care 3.1 Antibiotic/ Antimicrobial Stewardship	July 2016 – June 2017