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

Application due: **by 5:00 p.m. on April 4, 2016**

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General Instructions

Thank you for your interest in the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program. Your response to this 5-Year PRIME Project Plan ("Plan") will enable the Department of Health Care Services (DHCS) to assess if your entity can meet the requirements specified in the waiver Special Terms and Conditions (STCs) and has the capacity to successfully participate in the PRIME program.

This 5-Year PRIME Project Plan is divided into 10 sections which are structured around the Medi-Cal 2020 Waiver's Special Terms and Conditions (STCs). Additional information about the PRIME program requirements can be found in the PRIME Projects and Metrics Protocol (Attachment Q) and Funding Mechanics (Attachment II) of the STCs.

Scoring

This Plan will be scored on a "Pass/Fail" basis. The state will evaluate the responses to each section and determine if the response is sufficient to demonstrate that the applicant will be able to effectively implement the selected PRIME Projects while simultaneously conducting the regular business of operating the hospital system.

In the event that a response to a Plan section is not sufficient and fails to meet review criteria, the applicant will have an opportunity to revise the response(s) to meet the state's satisfaction. Applicants will have three (3) days to complete the revisions upon receiving feedback from the state.

Please complete all sections in this 5-Year PRIME Project Plan, including the Appendix (the infrastructure-building process measure plan as applicable), and return to Tianna Morgan at PRIME@dhcs.ca.gov **no later than 5:00 p.m. on April 4, 2016**.

Section 1: PRIME Participating Entity Information

Health Care System/Hospital Name Palomar Health (PH)

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.

Palomar Health (PH) is a healthcare district hospital, as defined by State law, which serves the North Inland Region of San Diego County (SDC). An analysis of the North Inland Region conducted by the HHSA in 2012 found that the high prevalence of chronic disease and high rates of obesity were top concerns for the Region. Similarly, the Hospital Association of San Diego & Imperial County's 2013 Community Health Needs Assessment (CHNA) found that cardiovascular disease and obesity were among the top health needs in the region.

In addition to the top health needs, the 2013 CHNA identified five broad categories of recommendations for hospitals to improve community health including access to care or insurance, care management, education, screening services, and collaboration. Access and chronic disease management were also identified as a common barrier for the SDC community.

Cardiovascular Disease: Nearly 7% of adults in the North Inland Region have been diagnosed with heart disease, compared to 6.0% in SDC. Additionally, 22.6% have been diagnosed with high blood pressure in the Region. "Diseases of the heart" is the second leading cause of death in the Region, accounting for 21% of deaths in the North Inland Region.

Obesity: More than half of the adults in the North Inland Region are overweight or obese. Additionally in the Region, 12.9 % of children age 2-11 are overweight and 27.1% of adolescents age 12-17 are overweight or obese.

Health Disparities: Nearly two thirds of the communities in the North Inland Region are considered to be high or very high need by the Dignity Health Community Need Index,

which provides a high-level assessment of community health needs based on income, culture and language, educational levels, insurance and housing. According to the 2013 American Community Survey, the two large North Inland communities of Escondido and San Marcos had a higher percentage of residents who are eligible for public programs, speak only Spanish, have not attained a high school degree and spend greater than 30% of their income on housing compared to the rest of the North Inland Region and SDC overall. These are all factors known to adversely impact health and hinder access to preventable care.

Coverage: With a shortage of physicians (77.5 in San Diego County per 100,000 population) and overall poverty (27.5% are uninsured) in the Region, PH is challenged to meet the healthcare needs of the community it serves. From Fiscal Year 2014 to Fiscal Year 2015, PH experienced a 49.5% increase in the number of Medi-Cal patients accessing care.

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 total population in SDC is 3,138,265 with the population density estimated at 746 persons per square mile. The North Inland Region is the largest region geographically within the County and home to 581,849 residents (approximately 18% of the county). The communities of the North Inland Region include urban, suburban, rural and remote areas and represent a low population density of 246.2 persons per square mile.

Income: Within the North Inland Region, 11.1% of the population has an income below 100% of the Federal Poverty Level (FPL) compared to 19.3% in California. Additionally, 27.5% are uninsured, and 14.1% of residents over 25 lack a high school diploma or equivalent. The average per capita income in the North Inland Region is $32,342 compared to $29,527 for California.

Race/Ethnicity & Language: North Inland is predominately white (53.89%), Hispanic (29.85%) and Asian/Pacific Islander (10.74%). While the majority of residents report speaking English (66.5%) only or being bilingual (16.5%), there remains a significant percentage (12.08%) of the population that report speaking Spanish only at home.

Age: Average age of North Inland Region residents is 37.5 years old, higher than the SDC median of 34.8. The age breakdown is as follows:

- 0-18 years: 26.9%
- 19-64 years: 59.3%
- 65 years+: 13.4%

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.

Palomar Health is the largest healthcare district by geographic area in California and serves communities in an 850-square mile area and has a trauma center that covers more than 2,200 square miles.

As of April 4, 2016, the health system includes the following:

- 288-bed Palomar Medical Center in Escondido
- 107-bed Pomerado Hospital in Poway (96 acute care, 12 acute psychiatric)
- 292-bed Palomar Health Downtown Campus in Escondido (267 acute, 26 acute psychiatric beds)

We provide a full spectrum of health services, which include:

- Acute inpatient care
- Maternal services including birthing, lactation, and education
- Acute rehabilitation
- Skilled nursing facility
- Home health care
- Hospice services
- Outpatient services such as wound care, physical therapy, behavioral health, speech therapy, occupational therapy, sleep lab, women's services and radiation therapy

Palomar Health is the first hospital in California to become a member of the Mayo Clinic Care Network (MCC). As a member, Palomar Health has formalized a relationship that fosters physician collaboration to improve the delivery of healthcare to our patients and communities.

At Fiscal Year end June 30, 2015, Palomar Health's payer mix was: 22% Medi-Cal (13% Medi-Cal Managed Care, 9% Medi-Cal FFS), 38% Medicare (23% Medicare FFS, 15% Medicare Managed Care), 2% Self-Pay, 23% Managed Care, 12% Capitation, and 3% Other.

Palomar Health had 123,192 acute patient days and 162,740 outpatient registrations in in Fiscal Year end June 30, 2015 and the average length of stay for acute care was 4.03 days.

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.

Collect, Report and Monitor: In 2015, Palomar Health (PH) created a multidisciplinary Data Analytics Steering committee to centralize and streamline our approach to data reporting and analytics. We have a number of different tools that we use to collect, report, and monitor performance. We currently use PowerInsight - Business Objects to create reports and dashboards out of our Cerner EHR system. For example, we have created an Operating Room Efficiency dashboard to help us monitor the performance in our Perioperative areas.

We use Care Discovery Advantage from Truven to benchmark our facilities against of similar hospitals to help us gauge and monitor our performance. We also utilize other systems to collect non-clinical data as well. All of these systems will help support the PRIME clinical quality reporting requirements. We are also in the process of creating an Enterprise Data Warehouse that will allow us to house data from multiple sources and create more effective dashboards and provide more efficient data analysis.

Once we establish our baseline data and reports, each PRIME project leader will regularly monitor and adjust performance against metrics. We will also create a PRIME Steering Committee to monitor overall progress of the program and work to remove barriers so that we can achieve the expected outcomes.

In some cases, PH will require data from external stakeholders in order to report on each measure. We will work with these external parties during DY11 and DY12 to establish data requirements and agreements for providing the necessary data.

Potential Barriers: Our two main potential barriers are the small size of our data analytics team and our lack of a complete Enterprise Data Warehouse. Our strategies to address these two barriers are to budget for additional data analysts and to pull data from multiple internal and external databases, as needed, until we implement the Enterprise Data Warehouse.

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.*

PH's overarching goal is to provide our patients with the right care, in the right place, at the right time, using the right resources. To execute this vision, our long-term goal for the organization is to transform toward value-based care. One of PH's strategic initiatives is to improve care coordination with the operational goal of improving patient satisfaction and improving patient throughput. PH's strategic roadmap includes the development of a Clinically Integrated network (CIN). As part of PRIME, PH will implement more effective approaches to guide patients through the continuum of care, including a focus on improved care management and care transitions to reduce avoidable utilization. This will support delivery system transformation as PH will be better able to provide care in the setting that is best suited to the patient's clinical and social needs.

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.*

We have two primary goals for PH's PRIME participation: 1) to develop a delivery model that supports care coordination and transitions across the continuum; and 2) to improve efficiency through standardization and value based decision-making to provide the right care to patients.

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;*

PH selected our ten projects (Projects 1.4, 1.5, 1.7, 2.2, 2.3, 2.7, 3.1, 3.2, 3.3, 3,4) based upon the hospital leadership's recognition of the need to better integrate care coordination into our delivery model and to improve efficiencies in the transition toward value-based care. Our project selections directly correspond to our organizational aims of developing a delivery model that strongly supports care coordination and to improve efficiencies as we work toward a delivery system that is focused on value to the patient, the system and the broader healthcare industry.

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 10 projects PH selected inter-relate in how we strive to deliver care. Each of our project selections intersects with our desire to provide more effective and efficient approaches, whether through patient care delivery systems or through improved resource stewardship. These projects will help PH's system transform toward value-based care which is a long-term goal of the organization. PH has identified improving care coordination as a strategic initiative for the organization which includes an operational focus on improving patient satisfaction and throughput. Each of these projects helps PH create a more efficient and effective delivery system to care for our patients' needs.

Most all of the projects have a care coordination component including establishing new care pathways and referral processes. We will leverage training and education of new and re-deployed staff across projects as this is a key component of projects to lead to system transformation and better clinical outcomes.

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.*

Palomar Health's strategy is built upon a foundation of 'patient first.' Key to achieving operational excellence will be our focus on clinical integration, efficient and effective delivery of care, and a focus on the community and the patients we serve.

PH has begun work toward population health and our participation in PRIME supports this focus. We are committed to building a connected, efficient, and effective system of care and wellness that includes our patients and families, employees, community, physicians, post-acute care providers, and other ancillary providers and contributors to the continuum of care. Further, our development of the CIN will include models of collaborative care using an interoperability platform, which will result in improved efficiencies and appropriate utilization of resources.

At the end of five years, we will have developed and tested new models to more efficiently and effectively meet our communities' healthcare needs in a manner that is sustainable for the long term. We also intend to decrease avoidable admissions, readmissions, and to develop a system that supports the patient as they transition from the acute to the ambulatory setting.

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

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

The prevalence of cardiovascular disease, as described in our response to Section 2.1, highlights PH's rationale to focus on cardiovascular health across several projects In addition to the health needs, the CHNA included community discussions and key informant interviews found care management is a critical service more patients need access to, particularly post-discharge. As a result, PH has chosen to address these needs through care transitions and care management projects (Projects 1.5, 2.2, and 2.3). All three of these projects will address the significant community need of patients with cardiovascular diagnoses through the development of better care management and patient involvement. In addition, many patients have co-occurring diagnoses, such as cardiovascular disease, obesity and diabetes, so PH selected projects that will begin to address these additional community needs (Project 1.7).

PH acknowledges that a key part of transforming the health care system is to create efficiencies and reduce costs where possible. Therefore, we have identified four areas where to create more value for limited health care dollars (Projects 3.1, 3.2, 3.3 and 3.4). Through Project 1.4, PH will work to improve patient safety across the continuum of care which will improve outcomes and reduce costs. Project 2.7 (Comprehensive Advanced Illness Planning & Care) is a program PH is adding based on the need. Community-based palliative care sufficiency for San Diego County is only 19%. Adding this program will improve the patient experience by ensuring the patient's treatment preferences at the end of life are respected and address an unmet need in the community.

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).

PH's strategic roadmap includes development of a Clinically Integrated network (CIN). Development of the CIN will help PH improve access, health and value. The CIN development requires implementation of an interoperability platform that will allow management of patients across the continuum of care and common use of data platforms, metrics and measurements, and evidence-based best practice. The CIN will support PH's efforts through PRIME.

In addition, PH will monitor organizational progress through our Balanced Scorecard (BSC) that brings focus and transparency around the core values of: Quality, Cost, Experience and Brand - all of which align closely with the outcomes of the PRIME projects. In order to promote transparency and focus, the BSC is reviewed at the Department and Leadership level, and quarterly in meetings of our public Board of Directors.

PH will also establish a governing committee to guide the PRIME projects and monitor progress toward PRIME goals, performance metrics and how those efforts that align with PH's strategic plan. The governing committee will include leaders from PH's operations and finance teams, as well as a representative from the Patient Family Advisory Council (PFAC).

PH will utilize a standard process improvement methodology across all PRIME projects, using collected data to monitor our progress and direct our improvement efforts. One of PH's organizational objectives is to use best practices to reduce waste and improve efficiencies and outcomes. Our Performance Engineers will engage in PRIME projects to guide and instruct our teams to improve workflow, and to develop and utilize data-driven decision-making.

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.

PH is committed to ensuring that stakeholders within the community are able to engage in PRIME implementation, which will be accomplished in multiple ways. We have a Patient Family Advisory Council (PFAC) that provides feedback and input regarding

patient and family experiences. A representative from the PFAC will sit on the PRIME committee. We will also present PH's PRIME projects to the PFAC to solicit their input and feedback.

PH's Community Action Councils (CACs) bring together leaders from a wide range of agencies and organizations that provide support services to our patients, as a way to collaborate to meet the needs of the community. The CACs created a direct connection between PH and the community to identify and affectively address the health care needs of our district. We will utilize those established relationships and present PH's PRIME projects to the regional CACs for an opportunity for input and feedback from attendees.

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.

PH recognizes the diverse population that it serves and has been implementing approaches to meeting the needs of our diverse community. We strive to ensure that the PH family, ranging from providers to staff, reflects the diversity of our community. We also provide patients access to health educational materials and literature in their language of choice. These activities are part of our commitment to providing culturally competent service and care to the communities we serve.

We will continue to provide real-time access to interpreter services through on-site and telephonic translators, in addition to access to provider's with multi-lingual capabilities. We will be building upon our existing outreach programs to proactively engage the diverse communities we serve.

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.

PH has a strong commitment to quality improvement and change management through participation in opportunities such as The Hospital Quality Institute California Hospital Engagement Network (CalHEN) and Health Services Advisory Group (HSAG). PH uses a standard PLAN-DO-CHECK/STUDY-ACT (PDCA) cycle to improve processes in

order to exceed patient expectations or improve operational efficiency. Using the PDCA cycle provides improvement teams with the knowledge to fix the actual cause of the problem, improve work processes, and make data-driven decisions. Traditional quality tools will be used throughout the various steps of the PDCA cycle, as needed.

Dashboards will be developed and used by operational leaders to regularly track progress on PRIME initiatives as part of their ongoing departmental responsibilities. PRIME teams will also report on their outcomes at regularly scheduled governing committee meetings where we will work together to remove barriers to improvement and leverage the experience we gain to sustain PRIME improvements.

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 <u>each</u> 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

☒ 1.4 – Patient Safety in the Ambulatory Setting

Palomar Health (DMPH) Project 1.4 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.

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]

Rationale: PH selected this project because it aligns with the system's current efforts to improve medication use safety across the continuum of care, and improve processes to follow-up on abnormal lab results. The failure to adequately monitor and adjust chronic medications can lead to adverse patient outcomes as well as avoidable admissions or readmissions to the hospital. Additionally, the failure to follow-up on abnormal lab results, such as Potassium, INR, and Mammograms, can lead to poor outcomes and ultimately higher health care costs.

Design and Implementation Approach: This project will be designed and implemented in partnership with two Federally Qualified Health Centers (FQHCs): Neighborhood Health and North County Health Services.

- *Clinical Pathways:* PH will establish clinical workgroups to examine current clinical workflow around persistent medications/warfarin and develop common clinical pathways starting in DY11.

- *Clinical Partnerships:* Mid-level providers, including pharmacists, will be utilized to monitor performance and to provide direct patient care starting in DY11. This care will include timely follow up on abnormal lab results.

- *Patient Outreach:* PH will develop systems to ensure that patients are contacted and directed to have the necessary tests performed starting in DY 11.

- *Performance Dashboards:* PH will develop data reporting capacities and implement a performance dashboard to track provider-specific performance in these areas starting in DY 11.

- *Rapid Cycle Improvement:* PH will design and implement performance improvement strategies based on the assessments of clinical workflows and on the data obtained in the performance dashboards starting in DY 11. These strategies will be deployed quickly and monitored closely to ensure that they achieve the desired results.

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

Target Population: There are two target populations for this project. The first target population will be Medi-Cal patients who are taking persistent medications. The second target population will be Medi-Cal patients for whom abnormal test results have been identified. Both of these populations will be Medi-Cal beneficiaries who access services at Palomar Health and either Neighborhood Healthcare and/or North County Health Services (FQHC).

Vision for Care Delivery: PRIME will enable our organization to partner with two local FQHCs to optimize patient outcomes. We believe that our work with project 1.4 will improve care for the Medi-Cal population by creating the infrastructure and processes that will ensure proper long term monitoring of persistent medication therapy, and will put in place the processes for follow-up for abnormal lab results. Through our work with this PRIME project, we believe that we will create processes and workflows that will decrease utilization, improve clinical outcomes, and improve the patient experience.

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

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

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

☒ 1.5 – Million Hearts Initiative

Palomar Health (DMPH) Project 1.5 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.

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]

Rationale: Palomar Health (PH) selected this project based upon the strong community need for improved access to and better outcomes for cardiovascular health. The 2013

[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.*

Community Needs Assessment shows that cardiovascular disease is one of the top community health needs in San Diego County. Nearly 7% of adults in the North Inland Region have been diagnosed with heart disease. Additionally, 22.6% have been diagnosed with high blood pressure in the Region. “Diseases of the heart” is the second leading cause of death in the Region, accounting for 21% of deaths in the North Inland Region.

Design and Implementation Approach: This program will reduce the recurrence of heart attacks and strokes by working with the index heart attack/stroke identified during patient admission when risk-awareness is at its highest and by enhancing discharge education and encouraging ongoing follow up care.

- *Referral Processes*: PH will proactively identify patients with, or at high-risk for, cardio/cerebrovascular disease utilizing the ASCVD risk factors by working with our District and community partners (e.g. Medi-Cal managed care organizations, medical groups, primary physician practices, specialists, outpatient clinics). Once identified, these patients will be assessed for risk with regards to hospital readmission, and social/clinical factors. PH will conduct outreach to connect patients with targeted interventions. This work will begin in DY11.

- *Care Team Formation*: An inter-professional team of health care providers and support staff will risk stratify patients and implement protocols for care, education, monitoring and reports. This work will begin in DY11.

- *Intervention Strategy*: Upon completion of a risk assessment tool that utilizes both medical and social factors, self-care measures and goal development will be identified. PH will integrate the recommendation of clinical preventive services into clinical workflows. Screening, education and treatment will be designed and implemented. PH will connect patients to existing community-based resources. This work will begin in DY12.

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

Target Population: PH will target Medi-Cal patients in our community who could benefit from the interventions of the Million Hearts Initiative. Working with the internal data from our electronic medical record, we will identify patients who have, or are at high-risk for, cardio/cerebrovascular disease.

Vision for Care Delivery*:* Because our providers will work collaboratively with community PCPs, medical groups, specialists, and community outpatient clinics to expand access to care for identified high-risk patients and to ensure plans of care are

executed and patients are educated and engaged, we will see an improvement in patient outcomes including adherence to treatment plans which will decrease heart attacks and strokes. The end goal of these efforts is to ensure at-risk patients are identified through validated screening tools, referred through coordinated efforts, educated, and treated. All of these efforts will not only improve patient outcomes but should reduce hospital readmissions and admissions which will reduce health care costs.

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 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.

☒ 1.7 – Obesity Prevention and Healthier Foods Initiative

Palomar Health (DMPH) Project 1.7 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.

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]

Rationale: As referenced in Section 2.1, data indicates that more than half of adults, 12.9% of children ages 2-11, and 27.1% of youth ages 12-17 within our community are overweight or obese. With an ever-present focus on preventative care, our hospital is committed to improving our front-line defense of obesity prevention through screening, enhanced services, data tracking and an increased focus on the causes and treatments of obesity.

Planned Design and Implementation Approach:

- *Obesity Screening and Referral*: Screen patients within our Emergency Department and other venues of care such as PH sponsored health programs in the community for out-of-range BMI and develop an EMR adaptation to improve the rate of referrals for patients within the necessary ranges. This will be implemented in DY 12.

- *Patient Tracking*: Develop improved tracking mechanisms for obesity and overweight patient follow-up within our EMR in order to ensure proper follow-up occurs and is documented. This will be implemented in DY 12.

- *Nutritional and Physical Counseling*: Implement nutritional and physical counseling for patients through expanded provider agreements and the potential placement of nutrition personnel in key patient-service settings. These additional resources would allow our facilities to provide on-the-spot or appointment based counseling for those in need. This will be implemented in DY 12.

- *Hospital Nutrition and Wellness Program*: Improve dietary guidelines within our main hospital facility in order to increase access to wholesome, fresh, nutritious foods and improve educational opportunities surrounding healthy lifestyle choices for our patients, guests and employees. This will be done in conjunction with our current contractors and through the guidance of the Partnership for a Healthier America's Hospital Heathier Food Initiative. This will be implemented in DY 12.

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

Target Population: This project will focus in on two key populations. For the BMI screening/follow-up and weight assessment and counseling portions, we will target the Medi-Cal population within our Emergency Department. For the healthier hospital food initiative, we will target all patients, guests and employees who visit our hospital's cafeteria through the implementation of a nutrition and wellness program in line with the Partnership for a Healthier America's Hospital Health Food Initiative.

Vision for Care Delivery: The PRIME Obesity Prevention and Healthier Foods Initiative will lay the framework for improved recognition and intervention for obese patients, improved patient service delivery, and dietary offerings throughout out the system. The targeted focus of Project 1.7 will support the long-term vision of Palomar Health's improved patient care through hopeful reductions in obesity and the overweight levels of our community. We anticipate these reductions coming in part due to the work of our facility to educate, diagnosis, track, treat and prevent causes of obesity through the PRIME program and beyond.

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

Check, if applicable	Description of Core Components
Applicable	**1.7.1** Collect or use preexisting baseline data on receipt and use of targeted preventive services, including any associated disparities related to race, ethnicity or language need.
Applicable	**1.7.2** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to USPSTF A and B Recommendations.
Applicable	**1.7.3** Improve access to quality care and decrease disparities in the delivery of preventive services.
Applicable	**1.7.4** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
Applicable	**1.7.5** Adopt and use certified electronic health record systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population

Check, if applicable	Description of Core Components
	management approaches (e.g., in-reach, outreach) to reduce gaps in receipt of care.
Not Applicable	**1.7.6** Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.
Applicable	**1.7.7** Implement a system for performance management that includes ambitious targets and feedback from patients, community partners, front line staff, and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology.
Not Applicable	**1.7.8** Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts.
Not Applicable	**1.7.9** Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.
Applicable	**1.7.10** Prepare for and implement the Partnership for a Healthier America's Hospital Healthier Food Initiative.

Please complete the summary chart:

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

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

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

Palomar Health (DMPH) Project 2.2 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.

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]

Rationale: Palomar Health (PH) selected this project with the recognition that the transition from the inpatient to outpatient setting is a critical point in the care continuum, when providers can link patients to appropriate ongoing care. PH will work to expand our existing Community-based Care Transitions program from the Medicare population to the Medi-Cal population. We will also improve coordination and continuity of health care management for our high-risk Medi-Cal patients. In 2015, PH's Medi-Cal readmission rates were 9.2% and the emergency utilization rates within 30 days of discharge were 12%. Lack of care coordination results in poor medical management of disease processes which leads to higher readmission rates and utilization of emergency services for episodic care.

***Project Design and Implementation Approach*:** Expanding our existing care transition program will enable us to improve care for patients across the system. We intend to:

- Develop and implement a workforce plan to reflect our approach to hire, train, and/or retrain staff as needed to meet the needs of our population. We expect to undertake this work in DY 11.

- Assess caseload ratios and hire and train new Community Based Care Transition coaches as needed to serve the target population. We expect to undertake this work in DY 11.

- Assign identified patients to care mangers to link them to available social and medical resources and assist them with navigating system. We expect to undertake this work in DY 12.

- Develop a tiered approach to service delivery so that intensity and frequency of services is matched with patient need. This will include determining what services are provided in-home, in a care setting or via telephone. We expect to develop this approach in DY12.

- Establish inclusion criteria for the target population (i.e. diagnosis, utilization, clinical referral, etc.) We expect to establish inclusion criteria in DY 11. Given the complexity of this process, we may refine the criteria in subsequent years.

- Engage patients to self-manage their health conditions by supporting the adoption of healthy behaviors. We expect to undertake this work in DY 12.

- Inpatient Discharge Pathways: PH will review validated risk stratification tools, and develop workflows around a risk stratification tool including an identification process for patients at risk for readmission. PH will review current discharge pathways and develop new pathways to improve care coordination for patients identified as being at risk for readmission. We expect to undertake this work in DY 12.

Target Population*:* The target population is adult Medi-Cal beneficiaries who have experienced at least one inpatient discharge during the measurement year. Given the complex needs of our patients, PH will work to expand our existing Community-based Care Transitions program from the Medicare population to the Medi-Cal population. We will begin by extending these services to Medi-Cal beneficiaries with cardiovascular disease and stroke and will expand to other target populations over time.

Vision for Care Delivery*:* This care transition program will improve our ability to support patients who could be at risk for unnecessary ED use or avoidable readmission in the absence of additional support. Transition coaches will work to engage patients in self-management support, including supporting the adoption of healthy behaviors which will improve health outcomes. Additionally, with the added support to the patient and their families during the transition, the program will help reduce avoidable readmission rates, length of stay, and inappropriate emergency usage for episodic care. In addition, it will improve patient and caregiver “readiness for discharge”, patient experience, chronic disease management, communication and coordination between providers, and access to post discharge primary and specialty care follow up.

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 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.

Check, if applicable	Description of Core Components
	Develop process for warm hand-off from hospital to outpatient provider, including assignment of responsibility for follow-up of labs or studies still pending at the time of discharge.
Applicable	**2.2.6** Develop standardized workflows for post-discharge (outpatient) care: • Deliver timely access to primary and/or specialty care following a hospitalization. • Standardize post-hospital visits and include outpatient medication reconciliation.
Applicable	**2.2.7** Support patients and family caregivers in becoming more comfortable, competent and confident in self-management skills required after an acute hospitalization by providing: • Engagement of patients in the care planning process. • Pre-discharge patient and caregiver education and coaching. • Written transition care plan for patient and caregiver. • Timely communication and coordination with receiving practitioner. Community-based support for the patient and caregiver post hospitalization focusing on self-care requirements and follow-up care with primary and specialty care providers.
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)

Palomar Health (DMPH) Project 2.3 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.

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]

Rationale: PH selected this project because the 2013 CHNA identified care management, access, and chronic disease management as a common barrier for the SDC community. Additionally, nearly 7% of adults in the North Inland Region have been diagnosed with heart disease, compared to 6.0% in SDC. Additionally, 22.6% have been diagnosed with high blood pressure in the region "Diseases of the heart" is the second leading cause of death in the region, accounting for 21% of deaths in the North Inland Region.

Design and Implementation Approach

- Develop and implement a workforce plan to reflect our approach to hire, train, and/or retrain staff as needed to meet the needs of our population. We expect to undertake this work in DY 11.

- Assign identified patients to care mangers to link them to available social and medical resources and assist them with navigating system. We expect to undertake this work in DY 12.

- Develop and utilize a tiered approach to service delivery so that intensity and frequency of services is matched with patient need. We expect to develop this approach in DY11.

- Establish inclusion criteria for the target population. Develop a risk stratification process/tool to identify high-risk/rising-risk patients. We expect to establish inclusion criteria in DY 11 and DY12. Given the complexity of this process, we may refine the criteria in subsequent years.

- Review current risk assessment process to determine areas of improvement and develop a uniform process/tool. We expect to undertake this work in DY 12.

- Engage patients to self-manage their health conditions by supporting the adoption of healthy behaviors. We expect to undertake this work in DY 12.

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

Target Population*:* The target population is adult Medi-Cal beneficiaries diagnosed with cardiovascular disease and/or stroke who have ≥4 of the 13 specified chronic conditions/comorbidities. PH will identify these high-risk patient populations utilizing both internal (i.e. hospitalizations, ED visits, and data from our rural health clinics) and external data sources (i.e. collaborating with health plans, clinics, and medical groups).

Vision for Care Delivery: A complex care management program for high utilizing patients will improve our ability to support patients with multiple chronic conditions who could be at risk for unnecessary ED use or avoidable readmissions in the absence of additional support. Our program will improve care transitions through several activities: identifying post-acute or post-ED discharge needs; connecting patients with community-based clinical and non-clinical services; developing and action plan; and monitoring progress. Transition coaches will also work to engage patients in self-management support, including supporting the adoption of healthy behaviors which will improve patient outcomes.

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.

Check, if applicable	Description of Core Components
Applicable	**2.3.4** Conduct a qualitative assessment of high-risk, high-utilizing patients.
Applicable	**2.3.5** Establish data analytics systems using clinical data sources (e.g., EHR, registries), utilization and other available data (e.g., financial, health plan, zip codes), to enable identification of high-risk/rising risk patients for targeted complex care management interventions, including ability to stratify impact by race, ethnicity and language.
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.
Applicable	**2.3.9** Ensure systems and culturally appropriate team members (e.g. community health worker, health navigator or promotora) are in place to support system navigation and provide patient linkage to appropriate physical health, mental health, SUD and social services. Ensure follow-up and retention in care to those services, which are under DPH/DMPH authority, and promote adherence to medications.
Not Applicable	**2.3.10** Implement technology-enabled data systems to support patients and care teams throughout the care management program including patient identification, pre-visit planning, point-of-care delivery, care plan development and population/panel management activities.

Check, if applicable	Description of Core Components
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.

☒ 2.7 – Comprehensive Advanced Illness Planning and Care

Palomar Health (DMPH) Project 2.7 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.

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]

Rationale: Palomar Health (PH) selected this project because of a commitment to make quality palliative care available to patients. Access to specialty palliative care is currently limited and currently occurs only after symptom exacerbation has resulted in hospital admission. This structure has resulted in patients having limited, untimely or no access at all to this service. In fact, San Diego County was assessed as being capable of meeting only 19% of its estimated need for community based palliative care.

Project Design and Implementation Approach: PH will provide palliative care using a unique collaboration between Palomar Health, The Elizabeth Hospice, and Lightbridge Hospice. We will convene a multidisciplinary workgroup to design, implement, and monitor the Palliative Care Program starting in DY11.

We will also implement in the following manner:

- Expand PH's inpatient palliative care program to Pomerado Hospital starting in DY12.
- Develop criteria for referral to the inpatient palliative care programs at both Palomar Medical Center and Pomerado hospital starting in DY 11.
- Develop protocols for referral to palliative care at time of diagnosis of advanced illness starting in DY 11.

- Develop protocols to improve completion of the POLST with eligible patients and participate in the state-wide POLST registry starting in DY12.

- Develop training program for healthcare team with focus on communication skills, advance care planning and symptom management. Pre/post evaluations of knowledge/understanding of palliative care principles will be conducted. Ongoing education will target areas identified as being in need of additional education. We plan to begin this work in DY11.

- For patients with advance illness transitioning between primary care, hospital, skilled nursing facilities and home based environments, develop processes to ensure that the patient's advance care plan is clearly documented in the medical record and transmitted in a timely manner to receiving facilities. We plan to complete this work in DY 12.

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

Target Population: The target population for this project are Medi-Cal beneficiaries who have stage 4 cancer or advanced end organ failure such as ESRD (End Stage Renal Disease) in patients 80 year old or greater; End Stage Liver Disease with a MELD score equal or greater to 30; Class IV CHF; stage IV COPD; advanced dementia (CDR 3) and neurodegenerative disease who are non-ambulatory.

Vision for Care Delivery: A palliative care program will improve our ability to support patients with progressive chronic illness as well as those with terminal diagnosis by providing patients with consultative physicians trained in having these difficult conversations about priority of care based on the patient and family experience. Our Palliative Care Program will increase access to care for symptom management, advance care planning, and engagement of the patient around shared medical decision-making and setting goals of care. The enhanced social, emotional and spiritual support provided by the palliative care service will positively impact overall chronic disease management as well as improve quality of life for patients and families served. By partnering with community and provider resources, the palliative care service will support improved communication and continuity of care. The expected reduction in emergency department visits and hospitalizations will free resources for new services that promote innovative advanced illness management strategies and programs within our system and the community.

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

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

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

Please complete the summary chart:

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

Section 4.3 – Domain 3: Resource Utilization Efficiency

☒ 3.1 – Antibiotic Stewardship

Palomar Health (DMPH) Project 3.1 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.

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]

Rationale: PH selected this project because we currently have significant improvements to make in this area. PH has had an Antibiotic Stewardship Program (ASP) for over 10 years and we have experienced tremendous benefits from this program, including improved utilization patterns, development of clinical protocols, improved resistance rates, and reduced pharmaceutical costs. However, even with all of these successes, there are still areas for improvement which will we use this opportunity with PRIME to make. For example, the observed/predicted number of Clostridium difficile infections (CDI) was 1.37 at Palomar Medical Center and 1.032 at Pomerado Hospital for CY15, and the CMS goal is to be below 0.75. With this project, we will expand our Antibiotic Stewardship Program into the new service areas of perioperative, emergency, and skilled nursing settings

Design and Implementation Approach: This project will expand of our existing Antibiotic Stewardship Program. Our ASP has utilized one pharmacist to manage 3 acute care facilities, and as such, interventions have been limited to specific areas, almost entirely in the inpatient setting.

- *Clinical Pathways:* PH will establish clinical workgroups to examine current clinical workflow around the treatment of bronchitis, low colony count urinary cultures, and C. diff. The group will develop common clinical pathways, procedures, and CPOE order sets starting in DY 11.

- *Education:* PH will develop and implement education efforts to providers and patients in order to guide evidence-based prescribing patterns starting in DY 11.

- *Active Surveillance:* PH will develop and implement a process for actively tracking patients, including electronic rule-based patient lists, to monitor adherence to clinical pathways starting in DY11.

- *Rapid Cycle Improvement:* PH will design performance improvement strategies based on the assessments of clinical workflows and on the data obtained in the performance dashboards starting in DY 12. These strategies will be deployed quickly and monitored closely to ensure that we achieve the desired results.

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

Target Population: The targeted population is Medi-Cal beneficiaries with any acute care utilization at Palomar Health during the measurement period.

Vision for Care Delivery: By improving oversight, we will be able to reduce antibiotic utilization, thereby reducing resistance pressure. By slowing/reversing the development of microbial resistance, patients will be at lower risk of developing an opportunistic infection or becoming infected with a multi-drug resistant organism and improve patient outcomes. PH envisions providers being well-versed on the principles of antimicrobial stewardship, following appropriate use guidelines, de-escalating antibiotic regimens as test results and the patient's condition warrant, and being empowered to not use antibiotics when they are not indicated.

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

Check, if applicable	Description of Core Components
Not Applicable	**3.1.1** Utilize state and/or national resources to develop and implement an antibiotic stewardship program, such as the California Antimicrobial Stewardship Program Initiative, or the IHI-CDC 2012 Update "Antibiotic Stewardship Driver Diagram and Change Package.[2] • Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**3.1.2** Develop antimicrobial stewardship policies and procedures.

[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).
Not Applicable	**3.1.7** Develop evidence-based computerized provider order entry (CPOE) algorithms and associated clinician training, to support antibiotic stewardship choices during order entry. These could include approaches such as guidelines for duration of antibiotics, within drug class auto-switching for specific antibiotics and doses, or restriction of specific antibiotics at the point of ordering (e.g., broad spectrum agents).
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: Click here to see this statistic's source webpage.

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.

☒ 3.2 – Resource Stewardship: High Cost Imaging

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]

Rationale: There are multiple reasons PH selected this project. PH currently does not have a hard wired process for clinical decision support to help enforce appropriate use of high cost imaging in patient care. This project will help implement solutions for improving physician communication and education related to high cost imaging studies and will encourage appropriate use of imaging services. Through the implementation of an imaging management program, PH will be able to streamline processes, improve clinical outcomes, and better manage patients.

Planned Design and Implementation Approach:

- *Audit current practice to identify opportunities*- PH will convene a working group to review current clinical workflow around the use of imaging studies. This group will develop common clinical pathways, processes for providers, and standards of care regarding the use of imaging. They will also develop a list of evidence-based, lower cost imaging modalities when imaging is warranted. We expect to start work on this in DY11.

- *Multidisciplinary/Team Based Approach* – Referring MDs, radiologists, PH leadership and IT will collaborate to vet and install software and set up programs

that will assist clinical decision support and appropriate use criteria. We expect to start work on this in DY11.

- *Care Team Training*: PH will assess the level of education across the care team regarding appropriate use of imaging. We will develop and implement a training program designed to address unnecessary or inappropriate studies. We are currently conducting a needs assessment, development of policies and procedures, and conducting initial staff training. We will conduct trainings ongoing thereafter as deemed necessary. We expect to start work on this in DY11.

- *Quality Improvement*: PH will implement a system for continual rapid cycle improvement and performance feedback that includes patients, front line staff and senior leadership. We expect to start work on this in DY12.

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

Target population: The target population for this project is Medi-Cal beneficiaries who are presenting in the emergency room and/or are admitted inpatient with symptoms that could indicate the need for the selected imaging studies (e.g. headache, PE, and low-back pain).

Vision for Care Delivery: PRIME will place PH in a position to accomplish several key objectives that are central to our ability to provide the highest quality, most cost-effective care to patients in our community. PH's goal with this project is to have providers use informed decision making processes in order to shift our culture of imaging. Including best practice standards and algorithms to assist with clinical decision support will allow physicians to have informed conversations with patients about care path options suitable for them, and will encourage informed decision making. Informed decision making by both the provider and the patient will lead to better health outcomes and will reduce health care costs. Making the best use of resources goes hand in hand with implementing best practices for care, making improvements in population health, and decreasing health care costs.

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

Check, if applicable	Description of Core Components
Applicable	**3.2.1** Implement an imaging management program, demonstrating engagement of patients in the design and implementation of components of the project.
Applicable	**3.2.2** Program should include identification of top imaging tests whose necessity should be assessed for possible overuse. Criteria for assessment could include: • Frequency and cost of inappropriate/unnecessary imaging: o Appropriate Use: Beginning with state- or nationally-recognized models or guidelines (e.g., American College of Radiology Appropriateness Criteria, American College of Cardiology Appropriate Use Criteria) and incorporating pertinent local factors, programs will set out definitions for appropriateness. o Cost: Programs will identify imaging studies associated with high costs due to high cost per study or high volume across the system. • Unwarranted practice variation within the participating DPHs/DMPHs. Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed. • Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed. • Whether there are established, tested and available evidence-based clinical pathways to guide cost-effective imaging choices.
Applicable	**3.2.3** Establish standards of care regarding use of imaging, including: • Costs are high and evidence for clinical effectiveness is highly variable or low. • The imaging service is overused compared to evidence-based appropriateness criteria. Lack of evidence of additional value (benefits to cost) compared to other imaging options available to answer the clinical question.
Applicable	**3.2.4** Incorporate cost information into decision making processes: • Develop recommendations as guidelines for provider-patient shared decision conversations in determining an appropriate treatment plan. • Implementation of decision support, evidence-based guidelines and medical criteria to recommend best course of action.

Check, if applicable	Description of Core Components
Not Applicable	**3.2.5** Provide staff training on project components including implementation of recommendations, and methods for engaging patients in shared decision making as regards to appropriate use of imaging.
Applicable	**3.2.6** Implement a system for continual rapid cycle improvement and performance feedback that includes patients, front line staff and senior leadership.

☒ 3.3 – Resource Stewardship: Therapies Involving High Cost Pharmaceuticals

Palomar Health (DMPH) Project 3.3 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.

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]

Rationale: PH selected this project because medication history documentation is a chronic problem across the continuum of care in our community and an area where we need to make improvements. We have heard that PH providers do not trust medication lists that are documented in the electronic health records, both in the hospital and in the community, as the belief is there are often mistakes or the lists are incomplete. In addition, there is significant opportunity with our patients to identify appropriate use of high cost pharmaceuticals, as well as become better at monitor and encouraging through education adherence in order to ensure optimal outcomes.

Design and Implementation Approach: By partnering with two local Federally Qualified Health Centers (FQHCs), Neighborhood Health and North County Health Services, PH will to the following.

- *Identification of High Cost Rx*: PH will begin to develop a data analytics process to identify the highest cost pharmaceuticals and will develop processes for evaluating impact of high-cost, high-efficacy drugs to treat conditions starting in DY 11.

- *Clinical Pathways:* PH will establish clinical workgroups to examine current clinical workflow and will develop and implement common clinical pathways (protocols) and procedures starting in DY 11.

- *Clinical Partnerships:* Mid-level providers, including pharmacists, will be utilized to provide direct patient care starting in DY12.

- *Performance Dashboards:* PH will develop data reporting capacities and implement a performance dashboard to track compliance with the metrics starting in DY11.

- *Rapid Cycle Improvement:* PH with design performance improvement strategies based on the assessments of clinical workflows and on the data obtained in the performance dashboards starting in DY12. These strategies will be deployed quickly and monitored closely to ensure that we achieve the desired results.

- *Care Team Training*: PH will develop and implement a provider training program designed to impact prescribing by providers by establishing standards of care regarding prescribing of high cost pharmaceuticals starting in DY11.

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

Target Population: The targeted population is Medi-Cal beneficiaries with an acute care utilization at Palomar Health during the measurement period who are also patients accessing services at either Neighborhood Healthcare or North County Health Services clinics.

Vision for Care Delivery: This project will optimize high cost pharmaceutical utilization and medication history documentation which will improve care and lower costs in the Medi-Cal population by creating the infrastructure and processes to ensure optimal selection of and adherence to high cost pharmaceuticals. Additionally, by improving medication list documentation, we will be able to improve patient outcomes.

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

Check, if applicable	Description of Core Components
Applicable	**3.3.1** Implement or expand a high-cost pharmaceuticals management program.
Applicable	**3.3.2** Implement a multidisciplinary pharmaceuticals stewardship team.

Check, if applicable	Description of Core Components
Applicable	**3.3.3** Develop a data analytics process to identify the participating PRIME entity highest cost pharmaceuticals (high-cost medications or moderate-cost meds with high prescribing volume). Identify high-cost medications whose efficacy is significantly greater than available lower cost medications. • Using purchase price data, identify the top 20 medications and medication classes, focusing on the following: Analgesics, Anesthetics, Anticoagulants, Anti-Neoplastics, Diabetes, Hepatitis C, Immunoglobulins, Mental Health (Anti-Depressants/Sedatives/ Anti-Psychotics), Respiratory (COPD/Asthma), Rheumatoid Arthritis. o Exclude Anti-Infectives and Blood Products (addressed in separate PRIME Projects).
Applicable	**3.3.4** Develop processes for evaluating impact of high-cost, high-efficacy drugs, particularly drugs to treat conditions (e.g., HCV) or to address circumstances (e.g., oral anticoagulants for patients without transportation for blood checks) more prevalent in safety net populations: • Consider criteria that include ability of identified medications to improve patient health, improve patient function and reduce use of health care services.
Applicable	**3.3.5** Develop processes to impact prescribing by providers by establishing standards of care regarding prescribing of high cost pharmaceuticals, including: • Use of decision support/CPOE, evidence-based guidelines and medical criteria to support established standards. • Develop processes to improve the appropriate setting for medication delivery including, transitioning pharmaceutical treatment to the outpatient setting wherever possible. • Promote standards for generic prescribing. • Promote standards for utilizing therapeutic interchange.
Not Applicable	**3.3.6** Improve the process for proper billing of medications, through clinician education and decision support processes.
Applicable	**3.3.7** Develop formulary alignment with local health plans.
Applicable	**3.3.8** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership rapid cycle improvement using standard process improvement methodology.

Check, if applicable	Description of Core Components
Applicable	**3.3.9** Develop organization-wide provider level dashboards to track prescribing patterns for targeted high cost pharmaceuticals. Dashboard to include comparisons to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.
Applicable	**3.3.10** Develop processes for working with providers with prescribing patterns outside established standards, to identify and reduce barriers to meeting prescribing standards: • Develop guidelines and provide staff training on methods for engaging patients in shared decision making for developing treatment plans within the context of the established standards.
Applicable	**3.3.11** Maximize access to 340b pricing: • Share templates for contracting with external pharmacies. To improve program integrity, share tools for monitoring of 340b contract compliance.

☒ 3.4 – Resource Stewardship: Blood Products

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]

Rationale: PH selected this project because blood transfusions are one of the most common procedures performed in the hospital and the procedure can be with significant risks. The decision to transfuse must outweigh the known and potential risks versus projected benefits of transfusion. Through the implementation of a patient blood management (PBM) program, Palomar Health will be able to streamline processes, improve clinical outcomes, and better manage blood products.

Planned Design and Implementation Approach:

- Multidisciplinary/Team Based Approach – Palomar Health will expand the current Transfusion Committee to include stakeholders responsible for the PBM program establishment, review current protocol/threshold and change protocol/threshold according to best practice, and clinician/patient education. The team will identify a physician champion who will promote PBM concepts to medical staff for approval and engagement. We expect to begin convening the transfusion committee and role assignments in DY 11. Likewise, we expect to

start review and modification of current protocol/threshold, as needed, during this time period.

- Audit current practice to identify opportunities – The transfusion committee will monitor blood utilization by reviewing 30 random cases base on the following metrics and will use this information obtained to form policies and procedures to implement system wide. We expect to start baseline data gathering in DY 11. Work in DY 12 will include random review of cases, monitoring of blood utilization, and review of practice. Work in DY13 -15 will be mainly audit and monitoring of blood utilization.

- Transfusion optimization – Once the current transfusion practice is modified, the transfusion committee will share data with physicians, and then plan, educate, and implement any changes. The committee will continue to audit and track utilization to review effectiveness of changes and monitor success. We expect to share baseline data with physicians during DY 11. Work in DY12 includes, procedure/policy planning and modification, physician/nurse education, and implementation of procedure/policy changes.

Describe how the project will enable your entity to improve care for the specified population

Target population – The target population will include adult Medi-Cal patients, 18 years or older, with elective orthopedic, cardiac, and hysterectomy procedures with any acute care utilization at the PRIME entity during the measurement period.

Vision for Care Delivery - PRIME will enable the laboratory to accomplish many key objectives and will be in alignment with Palomar Health strategic initiatives to achieve and maintain center of excellence status in orthopedic/spine, cardiac/cardiovascular care, and women's services. The Patient Blood Management program will address the appropriate use of blood and blood products, thus, improving clinical outcomes of transfusion for Medi-Cal patients and reducing adverse events from transfusion.

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.
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 cycle improvement that includes patients, front line staff and senior leadership.
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.
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):		**4**
Domain 3 Total # of Projects:		**4**

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 $ 20,201,500
- DY 12 $ 20,201,500
- DY 13 $ 20,201,500
- DY 14 $ 18,181,350
- DY 15 $ 15,454,147

Total 5-year prime plan incentive amount: $ 94,239,996

Section 9: Health Plan Contract (DPHs Only)

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

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

Section 10: Certification

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

Appendix Infrastructure Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date / End Date
1	Define and identify target population	• Convene project teams • with Data/Documentation staff • Discuss metrics and patient factors associated with a higher probability of being impacted by program • Define target populations • Identify target populations •	1.4, 1.5, 1.7, 2.2, 2.3, 2.7, 3.1, 3.3,	January 1, 2016-June 30, 2016
2	PRIME workforce gap analysis and staffing	• Conduct a gap analysis of current workforce resources and ability to support PRIME • Identify resource/staffing requirements needed to support PRIME data collection, reporting and monitoring • Create staff specific competencies for PRIME resources • Develop training program for staff supporting PRIME • Develop job descriptions • Recruit team members • Hire team members • Train new team members	1.4, 1.5, 1.7, 2.2, 2.3, 2.7, 3.1, 3.3	January 1, 2016-December 31, 2016
3	Implement system for continual performance feedback and rapid cycle improvement	• Convene a multidisciplinary work group to design and implement a system for continual performance feedback and rapid cycle improvement • Conduct an analysis of current performance feedback and rapid cycle improvement initiatives • Develop process to provide feedback to care teams	1.4, 1.5, 2.2, 2.3, 2.7, 3.1, 3.3	July 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date / End Date
		around preventive service benchmarks and incentivize QI efforts • Development of patient and staff surveys for targeted feedback of service design and implementation • Design workflows and documentation to reinforce patient engagement in plans of care • Develop and implement performance feedback and rapid cycle improvement initiatives policies and procedures • Implement performance feedback and rapid cycle improvement process		
4	Creation or Expansion of data reporting systems for PRIME	• Conduct a gap analysis of current data system and its shortcomings • Identify gaps in current EMR and potential changes needed to support • Identify resource/staffing requirements needed extract and analyze data • Implement changes necessary to EMR to support data needs • Implement changes necessary to data analytics system/support to support data extraction and analysis • Identify metrics needed for performance monitoring • Work with IT to ensure proper metrics for project are capture and tracked with regards to improvements	1.4,1.5, 1.7, 2.2, 2.3, 2.7 3.1, 3.3	January 1, 2016- December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date / End Date
		• Build data elements within EHRs • Train clinical staff on clinical documentation needed to capture data elements • Report to identify patients with Medi-Cal and eligible conditions real time • Develop report template to track target population • Build reports • Establish reporting schedule and distribution process		
5	Secure patients and referral sources	• Identify patients who would qualify/benefit from programs/projects through hospital data • Identify potential referral sources in the community for target populations • Market to potential referral sources • Recruit patients to programs/projects	1.4,1.5, 1.7, 2.2, 2.3, 2.7 3.1,3.3	January 1, 2016-December 31, 2016
6	Develop processes for reporting and responding to abnormal test results	• Establish workgroup to evaluate current-state process flows for reporting and responding to abnormal test results. • Identify failure modes in process. • Design process changes to address failure modes • Develop procedures based on revised process flows • Educate impacted staff on process flow changes • Monitor processes and meet regularly to review findings and adjust as needed	1.4	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date / End Date
7	Develop processes to monitor patients on persistent medications and warfarin	• Establish workgroup to evaluate current-state process flows for reporting and responding to abnormal test results • Identify failure modes in process • Investigate options for leveraging EHR or Population Health software to identify and track target patients. • Design process changes to address failure modes • Identify criteria for referring patients to pharmacist clinic • Develop procedures based on revised process flows • Establish performance metrics and performance goals • Educate impacted staff on process flow changes • Monitor processes and meet regularly to review findings and adjust as needed	1.4	January 1, 2016-December 31, 2016
8	Develop a pharmacist-run clinic within the FQHC's	• Establish contractual arrangement between Palomar Health and participating FQHC's • Creation of Collaborative Practice Agreements with PCP's, which include clinical protocols • Establish physical space allocation for clinic • Determine criteria for various intervention strategies (mail outreach, telephone visit, clinic visit, etc.) • Design operational workflows for pharmacist-patient visits	1.4, 3.3	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date / End Date
9	Develop and implement population health strategy	• Modify current population health management software to assist with identifying the selected patient population • Partner with Medi-Cal managed care companies and at-risk medical groups to leverage data to identify high-risk patient populations • Develop outreach process for identified high-risk patients	1.5	January 1, 2016-December 31, 2016
10	Develop infrastructure for additional CCTP patients	• Hire and train additional coaches • Ensure adequate pharmacy support for medication reconciliation and accurate medication history. • Complete contract with county for care enhancement services • Physician and staff education • Develop process to track and review readmissions	1.5	January 1, 2016-December 31, 2016
11	Develop partnership with Express Care clinics for patient follow up post discharge from the hospital	• Work with developing process for patient follow up through outpatient clinic. • Ensure proper staffing in follow up clinic to support targeted population volume	1.5	January 1, 2016-December 31, 2016
12	Development and deployment of clinical and staff education on care model	• Convene a workgroup that includes clinical team to conduct a needs assessment, research best practices and ensure evidence-based care is provided in a team model for hypertension, aspirin utilization, cholesterol and smoking cessation • Develop curricula modules for targeted disease states (i.e. hypertension, aspirin	1.5	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date / End Date
		utilization, cholesterol and smoking cessation) and patient engagement and education strategies • Schedule and conduct ongoing trainings of interventions for patient in both inpatient and outpatient settings. • Assess effectiveness of trainings		
13	Develop staff training	• Train staff with regards to documentation of interventions for patient in both inpatient and outpatient settings. • Train outpatient staff with regards to blood pressure management guidelines, antithrombotic therapy and/or smoking cessation.	1.5	January 1, 2016-December 31, 2016
14	Develop processes to provide recommended clinical preventive services in line with national standards	• Convene work group to establish work flows • Review established policies • Draft/revise policies in support of process/workflow implementation • Seek appropriate committee approvals for polices. • Train staff on processes and workflow	1.7	Jan 1, 2016-December 31, 2016
15	Prepare for and implement the Partnership for a Healthier America's Hospital Healthier Food Initiative	• Convene the project team and develop a plan for implementation. • Implement Partnership for Healthier America's Hospital Initiative	1.7	January 1, 2016-Dec 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date / End Date
16	Develop infrastructure for additional CCTP patients	• Hire and train coaches • Ensure adequate pharmacy support for medication reconciliation • Complete contract with county for care enhancement services • Train Physician and staff • Develop process to track and review readmissions •	2.2, 2.3	July 1, 2016-Dec 31, 2016
17	Develop a risk stratification tool to identify patients at risk for re-admission for care transitions program	• Perform an evidenced-based literature search to identify validated tools • Develop and implement a process high risk (screening tool) including utilization of data and information technology, to reliably identify hospitalized patients at high-risk for readmission • Implement high risk screening tool to identify patients at risk for readmission • Train and educate staff on high risk screening tool to identify patients at risk for readmission • Investigate system-specific root causes/risk factors for readmission and develop or identify evidence based interventions to address these problems	2.2, 2.3	January 1, 2016-December 31, 2016
18	Develop partnerships with Federally Funded clinics	• Work with IT to ensure timely transmission of transition record • Work with federally funded clinics and managed care payers to provide medical home and care coordination	2.2, 2.3	July 1, 2016-Dec 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date / End Date
19	Improve care transitions program by establishing a transition care team	• Create a strategic plan for the program, including the mission, vision and goals • Conduct a workforce gap analysis to determine staffing needs for program • Develop staffing plan based on need • Develop a job description for staff based on needs of program • Recruit and hire staff for all project components based on need	2.2	January 1, 2016-December 31, 2016
20	Develop and implement structure for obtaining best possible medication history and assessing accuracy of list for care transitions program	• Conduct an overall analysis of the accuracy of current home medication list tool • Develop education and training program for staff involved in the collection of medication histories for hospitalized patients • Develop clinical workflow • Develop documentation tools • Develop policies and procedures • Conduct a follow up overall analysis of the accuracy of changed home medication list tool	2.2	January 1, 2016-December 31, 2016
21	Develop discharge medication reconciliation standards and subsequent patient education about medications for care transitions program	• Develop education and training program for staff involved in performing discharge medication reconciliation and education • Assess resources and tools needed to support patient education • Develop workflow • Develop documentation tools	2.2	July 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date / End Date
22	Develop standardized workflow for transition of care team	• Conduct literature review to determine and select the most appropriate model to use for standardized workflows • Standardized all workflows and protocols for the program to include discharge planning, access to PCP, multidisciplinary involvement, medication reconciliation and post-acute care needs • Develop training materials on role of the discharge advocate in the discharge workflow • Train staff on protocols and workflows	2.2	January 1, 2016-December 31, 2016
23	Develop system to support care transitions program including discharge process	• create system to track and report readmissions, timeliness of discharge summaries and other transition processes as well as other required metrics • Develop and implement an electronic communication tools needed for discharge advocate program • Train/educate appropriate staff on how to use system • Develop discharge tools for engagement of patients, caregivers and families in care planning process to include education, coaching, transition care plan and communication about post-acute care needs • Develop and implement training and education program to staff for patient's caregivers and families on the discharge resources available	2.2	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date / End Date
		• Train hospital staff who are involved in the discharge process (i.e. bedside nurses) on the role of discharge advocates • Develop and implement a plan to increase the number of strategic relationships with community based agencies		
24	Development of quantitative data triggers to identify high-risk patient populations who may benefit from care management	• Convene a workgroup of data analysis and population health management experts • Establish actionable and validated patient identification criteria and tools to identify targeted populations • Create a report of high-risk, high-utilizing patients and tier them by complexity score/level of risk • Partner with other community and industry stakeholders to leverage data to identify patient populations	2.3	January 1, 2016-December 31, 2016
25	Conduct a qualitative assessment of high-risk, high-utilizing patients	• Convene a workgroup with a background in qualitative research and needs of high-risk utilizing patients • Develop a survey tool to assess the needs and utilization patterns of high risk, high-utilizing patients • Develop patient surveys for targeted feedback of service design and implementation • Survey sample of patient population • Analyze survey results • Design workflows and documentation to reinforce patient engagement in plans of care	2.3	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date / End Date
		• Incorporate findings into strategy to better manage this population		
26	Development and deployment of clinical and staff education on complex care management model	• Convene a workgroup to conduct a needs assessment, research evidence based practice guidelines, best practices and make recommendations on an approach • Develop curricula modules • Schedule and conduct trainings • Assess effectiveness of trainings	2.3	January 1, 2016-December 31, 2016
27	Development of a multi-disciplinary complex care management 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	• Assess current needs of target population and identify types of staff that can address those needs • Develop job descriptions and defined duties for each team member • Recruit and hire for each position • Design continual training for team members on care model • Develop policies and/or protocols that enable team members to practice at the top of their license • Develop process to assign patients to members of care team based on level of risk	2.3	January 1, 2016-December 31, 2016
28	Develop a strategic plan for the palliative care program including partnerships with Hospice and referrals with community	• Establish Palliative Care Program Committee • Establish Inpatient Palliative Care Program sub-committee • Establish Outpatient Palliative Care Program sub-committee • Create mission & vision statement	2.7	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date / End Date
	based organizations	• Establish long-term and short-term goals and objectives for the inpatient and new outpatient Palliative Care Program • Perform workforce gap analysis of palliative care needs in community • Develop plan for increasing community awareness • Identify potential Hospice program partners • Develop communication and referral processes with Hospice programs • Work with hospice staff to track patients who expire with less than 3 days on hospice • Develop referral process for inpatient • Develop referral process for outpatient • Develop referral process for home health • Develop referral process for skilled nursing facilities • Develop referral process from and community based services • Draft policies and procedures for internal referral processes • Draft policies and procedures for internal referral processes • Train internal and external staff on referral process		
29	Develop a palliative care training program	• Develop training program with focus on communication and symptom management • Create staff specific competencies that ensure staff have the understanding	2.7	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date / End Date
		and skills necessary to provide Palliative Care Services • Develop and implement Primary Palliative Care Training for frontline staff and clinicians, and process for updating and evaluating competencies		
30	Develop a comprehensive advance care planning process	• Review literature around advanced care planning best practices • Develop protocols for advanced care planning • Develop advance care planning tools • Develop training modules on advance care planning • Train staff on modules and protocols • Implement advance care planning process • Develop policies and procedures for documentation of advance care planning preferences in EMR • Train palliative care staff to submit completed POLST to statewide registry	2.7	January 1, 2016-December 31, 2016
31	Develop improvement strategy (ASP & High Cost Pharmaceuticals)	• Convene recurring interdisciplinary utilization steering workgroup(s). (One workgroup for Antimicrobial Stewardship, and another for High Cost Pharmaceuticals.) • Identify areas for improvement and determine which areas will be targeted • Establish metrics to monitor targeted areas of improvement	3.1, 3.3	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date / End Date
		• Design strategies for improving outcomes		
32	Develop and deploy clinical pathways (ASP & High Cost Pharmaceuticals)	• Convene recurring interdisciplinary clinical pathway workgroup(s). (One workgroup for Antimicrobial Stewardship, and another for High Cost Pharmaceuticals.) • Based on published literature/guidelines and performance data, establish best practice guidelines in the areas targeted for improvement. • Obtain Medical Staff approval and endorsement of clinical pathways. • Design changes/additions for CPOE order sets. • Deploy CPOE changes/additions. • Deploy education to prescribers on new pathways/order sets.	3.1, 3.3	January 1, 2016-December 31, 2016
33	Establish high cost pharmaceutical oversight program	• Obtain prescription utilization data for target population. • Analyze prescription utilization data and select the high cost pharmaceuticals to be targeted. • Establish referral criteria for pharmacist-run clinic • Design and implement intervention strategies (e.g. patient outreach, provider education, formulary management, etc.)	3.3	January 1, 2016-December 31, 2016

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