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

Sierra View Medical Center (formally Sierra View District Hospital)

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.

Sierra View Medical Center (SVMC) is located in the Central Valley of California and provides health care services to residents of Tulare County. This region has pockets of urban areas but is largely rural with businesses being predominately anchored around agricultural-dairy industries, with oranges, grapes, and cattle-related commodities. The largest community in the County is Visalia-Porterville, which is where the hospital is located.

Physical Health: The 2016 Community Health Needs Assessment for Tulare County ranks the top 5 concerns as: access to care; diabetes; obesity; breathing problems (Asthma) and mental health. Tulare County ranked in the lower quartile for health outcomes (length and quality of life 45 out of 58) and Health Factors (determinants of health 56 out of 58)

Coverage: Access to primary care is a specific challenge as Tulare County is in a Health Professional Shortage Area (HPSA) with only 42.5 primary care physicians per 100,000 population compared with 72.2 in California. Many of the primary care providers in the community are in private practice where some do not accept Medi-Cal patients. Those private practice providers that do accept Medi-Cal have large caseloads and are often impacted so they can't accept new patients.

In Tulare County, 33.5% of adults have no regular physician and 29% have no insurance compared to 27% and 24%, respectively, in California. These factors impact rates of preventable hospitalizations, which is 59.1% per 1,000 Medicare enrollees in Tulare County compared to 45.3% for California.

Those receiving Medi-Cal benefits in the county are 40.2% of the population with an uninsured rate of 30.3% versus the State's 24.71%.

Health Disparities: Disparities are pervasive within our service area and poverty is abundant. Poverty and a lack of healthy food have a major impact on health. Consider that 43.8% of children in Tulare County compared to state average of 38% are overweight or obese. Rates of prediabetes are disproportionately high among young adults of color, with more than one-third of children between ages 18-39 are estimated

to have prediabetes. Nutritional/ metabolic disorders rank fourth in SVMC hospital readmissions.

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.

Race/Ethnicity/Language: SVMC serves a population of 446,644 largely comprised of Hispanic/Latino residents (61.24%). In fact, between 2000-2010, the growth in the Hispanic/Latino population accounted for 43.8% of the overall 20.16% increase in the total population. While the primary language spoken is English, within the county, 22.58% are of limited English proficiency compared to the State's 19.35%.

Age: The residents of the county are of a younger grouping as the median age is 29.9 compared to the State's 35.4. The age of the population is as follows:

- 0-17: 143,945
- 18-65: 259,397
- 65 and older: 43,302

The percentage of families with children is 48.37% compared to the State at 36.51%.

Income: Poverty is an overarching issue with 53.98% of households having an income below 200% FPL. County residents show a per capita income of $17,894 compared to $29,527 for California. This could be attributed to the amount of seasonal work as the region served is largely agricultural.

Public Assistance/Education: The unemployment rate for Tulare County is 12.2% vs 7.77% for California and those receiving public assistance is 9.1% vs 3.95% for California. 31.99% of the County's population has no high school diploma compared to the State's 18.76%. 72.74% of students qualify for free school lunch compared to California's 56.33%. 21.42% Tulare County residents compared to 8.07% Statewide receive Supplemental Nutrition Assistance Program benefits. Of the 21.42%, 94.15% are of minority class.

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.

SVMC is a 167-bed, full-service Joint Commission Accredited acute care facility. We provide acute inpatient, outpatient and emergency care as well as diagnostic services. Of our 167 beds, 10 are ICU, 10 perinatal, and 4 NICU. In addition, we also have a 35 bed SNF that accepts ventilator dependent residents. An Urgent Care Center is due to open Fall 2016. Care is available 24 hours a day, seven days a week to all in the community regardless of ability to pay.

We have received special recognition in Imaging (ACR accreditation) and Maternity Care (First 5 Hands-on Hero Award). Recent enhancements include a new linear accelerator, and 3D digital mammography. A cardiac cath lab is due to open mid-2016.

SVMC provides services to the community through the hospital, as well as through our outpatient centers including:

- Outpatient chronic dialysis center
- Cancer treatment center (radiation and chemotherapies)
- Ambulatory Surgery Department
- Wound Treatment center with two HBOs
- Physical rehabilitation
- Urology clinic in partnership with USC

Key Sierra View Statistics for FY 15 *(July 1, 2014-June 30, 2105):*

- 24,052 Number of acute inpatient days
- 1,542 Newborn delivery
- 113,077 Number of outpatient visits
- 46,051 Number of ED visits
- 1,686 Observation Patient Days

Key Sierra View Statistics *– Payer Mix for 2015:*

- 17.89% Commercial
- 40.23% Medi-Cal
- 40.96 Medicare (Inpatient and outpatient)
- .92% Other (uninsured)

Readmissions*: Q2 2014-Q1 2015*

- Rate 17.44
- Top Diagnosis: Simple Pneumonia, Heart Failure, COPD, Nutritional & Misc. Metabolic Disorders

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.

Data Collection: SVMC has implemented an electronic health record (eHR). Workflows are designed to register, room, treat and discharge patients in a timely fashion. Data are captured and entered into the eHR during all stages of the patient visit. These data are accessible 24/7 to medical providers and appropriate personnel. This same eHR system will provide support for PRIME data collection.

Reporting*:* The eHR is augmented by data extraction software that can produce reports. Software applications are also available to create dashboards useful for monitoring key metrics. A similar process will be used for reporting for PRIME.

Monitoring*:* The information provided in reports or dashboards can be used to identify areas where rapid cycle improvement projects will be most effective to improve the patient experience, improve overall population health and reduce costs. This monitoring process will be critically important to ensuring that the PRIME projects are effectively making improvements.

Potential Barriers*:* The hospital's information system is capable of producing standardized reports, some of which contain data useful to project metric reporting. However, it is clear that there are limitations with these standard reports and additional special reports will be needed to satisfy project requirements.

Additionally, the small size of our Information Technology (IT) Department creates resource issues. To address both of these potential barriers, SVMC will convene a data/documentation task force to address the required reporting and documentation needs of the PRIME projects. We will also hire a project manager who will lead this group and will have responsibility for defining data/documentation parameters and reporting structures necessary to meet PRIME metric reporting requirements and documentation needs. The project manager will work directly with the task force and specific vendors to remove obstacles to data capture, and enable full, timely reporting on all PRIME metrics.

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.*

SVMC's strategic goals support and align with delivery system transformation as evidenced by the adoption of our new vision statement: "Strengthen the quality of life through the delivery of integrated health care programs and services that promote access, care coordination, and patient care experience." This new vision statement is supported by organizational goals to do the following:

- Improve care transitions and coordination to reduce readmission
- Partner with physicians to develop patient centered medical home models
- Improve timely access to services
- Manage cost structure to reimbursement reductions.

Our participation in PRIME will allow us the opportunity to build and establish the programs in support of this vision and will help in the attainment of our goals.

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.*

SVMC has three main aims for PRIME: (1) develop culturally, and linguistically sensitive programs that (2) provide patients with access to information and services that will remove obstacles to care and empower patients to self-manage their conditions and to

(3) improve care coordination in the transition from inpatient to community based whereby reducing the likelihood of the patient experiencing a (re)hospitalization.

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;*

The four projects selected support the identified goals and aims in three ways. First, all of the projects have a care coordination component which will better support patients and improve access to care as well as outcomes. Second, all the projects have an aim to provide patients with access to information and services to empower them to self-manage their conditions. Lastly, they will improve timely access to services.

SVMC believes that access to education, care coordination, monitoring and supportive services will empower patients to take control of their health, thus decreasing the likelihood of disease progression, complications or unnecessary healthcare expenditures.

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*

All four projects are inter-related and share the goals/aim of improving timely access to care while improving care coordination. By redesigning inpatient care coordination, we will prepare patients for self-care to include referral to the chronic disease center. Those with chronic diseases may also, at some point, become eligible for palliative services. Those in the community who have been identified as obese will also be eligible for services at the center that will focus on lifestyle coaching and behavioral changes so as to decrease the likelihood of suffering from obesity related chronic diseases. Participants in any of the four projects will have the benefit of receiving services/referrals that will address social determinants of health to decrease health disparities.

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.*

The patients we serve will have the benefits of an infrastructure of care coordination and outpatient support services, plus gain access to skilled care partners (i.e. pharmacists, registered dietitians, social workers, care coordinators) that is currently lacking due to a shortage of primary care and infrastructure. Collectively, these efforts will improve clinical outcomes for patients. Ultimately, these programs and services will support our goal of delivery system transformation and improving population health.

Sierra View expects to transform the health system at the end of the five years in the following ways:

- **Clinical**:
  - Patients will receive access to new care processes and newly established community resources
  - Clinical Care providers at SVMC will be better trained and have the tools required to partner with the patient to manage their care in order to produce better health outcomes
- **Population Health**:
  - Expanded use of advanced illness planning, for end-of-life care in comfortable and appropriate care settings
  - Increased use of prevention screenings and standards of care to improve outcomes and quality of life
  - Increased use of care coordination and patient centered care to improve outcomes and quality of life
- **Fiscal**:
  - Reduced readmission rates and cost of care due to focused management of patients with chronic illnesses

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 data presented in section 2.1 supports the need for SVMC to address the gaps in programs and services in the community that contribute to poor health and poor care outcomes. Establishing a chronic disease center will address issues of diabetes, kidney disease and other associated chronic conditions and it should reduce the number of readmissions and emergency department utilization and increase access to care.

Offering a focus on community-wide programs that reduce obesity should result in a decrease in the incidence of pre-diabetic conditions and stave off the development of diabetes and renal disease in later years while improving quality of life. This culturally

competent program will focus on linkage to healthy foods and understanding healthy food choices and physical fitness.

Improving the care transition process within the acute setting will work to address the challenges currently faced in a population that lacks resources for successful health maintenance. Specifically, by establishing methodologies to identify at risk patients, developing care pathways sensitive to cultural and economic challenges and providing a focused approach involving care coordinators, patients will enjoy greater success in self-management post-discharge.

The palliative program is a natural partner to the chronic disease center and will allow patients and families access to options that will potentially increase the quality of end of life. We also believe it will ultimately reduce the over-utilization of services experienced in the final few days of life.

3.3 Infrastructure and Alignment with Organizational Goals. [No more than 250 words]

Describe the organizational infrastructure that exists or will be established for purposes of implementing PRIME (e.g., current strategic plan, goals related to quality improvement, monitoring/feedback mechanisms, data-driven decision-making practices).

The Local Health Care District of Sierra View was established in 1947 by the community for the community. Our board members are elected via public vote. Both the board and senior leadership are committed to providing the best care and services for the community as SVMC is the only hospital within 35 miles. Our vision statement and strategic goals reflect our commitment to and recognition of our responsibility as the primary healthcare provider to the community we serve.

To coordinate the PRIME effort and drive transformation, a new Population Health department has been established where the focus will be to develop and promote programs in support of delivery system transformation. It is within this department that the PRIME projects will be coordinated and managed.

In February 2016, SVMC established a PRIME Project Team (PPT) to craft and carry the vision for PRIME within our organization. The PPT is a Subcommittee of, and reports to, the Population Health Committee. Within the Population Health Committee, the PPT's role is to: 1) Review project metrics, make recommendations for improvements, monitor for successful achievement of milestones. 2) Provide input in resolving obstacles to success. 3) Review project submission papers and recommend modifications 4) Seek ways to further integrate and expand on PRIME initiatives to insure sustainability.

We anticipate the PRIME Project Team to convene at least monthly during the implementation phase. PPT activities will be brought to the board of directors through the Population Health Committee Report.

Executive Leadership's role in PRIME oversight will be to keep all projects, goals, and resources aligned and on budget, including a solid handle on the resource capacity and accountability. The hospital's executive leaders will promote transparency among the project groups and will ensure all project needs and goals are weighed appropriately when prioritizing. This will be done by incorporating the Executive Leadership into monthly PRIME team meetings, as appropriate.

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.

SVMC understands the importance of stakeholder involvement. As such, we plan to add the following to the Population Health Committee: 1) Community member of Hispanic/Latino heritage, 2) Member from a local Community Based Organization (CBO), 3) Managed Medi-Cal representative, and 4) Medi-Cal beneficiary. These are in addition to physician and multidisciplinary care provider's participation on the committee.

As stated above, the PRIME Subcommittee reports and activities will be reported up to the Board through the Population Health report. We will provide an opportunity for questions and comments from the public during all board meetings as well in order to provide an opportunity for public input.

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.

SVMC has a robust program to address those of limited, to no English proficiency. We have available on-site, dedicated, Spanish language interpreters as well as a language line which is available 24/7. This compliments our "front line" employee's language capabilities as many are bi-lingual. System-wide we are in compliance with the requirement to have key documents available in our identified threshold language (Spanish). Our on-line print ready patient education materials are also available in up to ten different languages. Our language sensitive programs and practices will carry over and be incorporated into all of our PRIME projects.

We currently offer community education classes in Spanish including child birth, breastfeeding and meal planning. We will expand these classes to include educational programs and classes related to the achievement of PRIME project goals and will do so in a culturally and linguistically appropriate manner.

SVMC will continue to participate in community-wide health fairs to include the native Tule River Indian Tribal Health Fair and to offer materials to the public in alternate languages.

It is our practice to require all staff to receive education in cultural sensitivity. Additionally, all PRIME related position postings with patient contact, will contain a "bi-lingual preferred" statement.

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.

SVMC utilizes PDCA as a systematic approach for quality improvement. We have successfully used this approach as a participant in many learning collaboratives and quality improvement initiatives, such as Beacon's sepsis and elective delivery initiatives. As such, we are well versed in change management principles and techniques in support of quality improvement.

SVMC will support improvements in each PRIME program through:

- *Plan*: Analyze current state (Gap Analysis), identify problems, and define targets.
- *Do*: Develop and implement countermeasures to address problems and close the identified gaps.
- *Check*: Monitor outcomes to test if the countermeasures were successful.
- *Act*: Spread the change to all applicable areas.

These four steps will be used throughout the life of the PRIME programs as a part of a never ending cycle of continual improvement and will be coordinated by the Population Health department as outlined in Section 3.3.

Section 4: Project Selection

The PRIME Projects are organized into three Domains:

- Domain 1: Outpatient Delivery System Transformation and Prevention
- Domain 2: Targeted High Risk or High Cost Populations
- Domain 3: Resource Utilization Efficiency

The PRIME program will provide incentive payments to participating entities that commit to implementing 5-year projects within the PRIME domains and as further described in *Attachment II -- PRIME Program Funding and Mechanics Protocol.* The required set of core metrics for each project is outlined in *Attachment Q: PRIME Projects and Metrics Protocol.* The purpose of this section is for applicants to indicate which projects they will implement and to describe the approaches to implementation.

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

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

- Select at least four projects from Domain 1 (Projects 1.1, 1.2, and 1.3 are required);
- Select at least four projects from Domain 2 (Projects 2.1, 2.2, and 2.3 are required); and,
- Select at least one project from Domain 3.

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

Instructions

For Sections 4.1 - 4.3, click the box(es) that correspond to the project(s) you will undertake. In addition, click the boxes that correspond to the core components you will adhere to in order to achieve the objectives of the project. Note that core components selected are not required; they are meant to guide project execution and serve as recommendations only.

Answer all of the questions below for each selected project. Provide narrative responses in the spaces marked *"[Insert response here]":*

1. *Summarize your approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words]*

2. *Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]*
3. ***For DMPHs (as applicable),*** *indicate which project(s) your entity is selecting that will require infrastructure-building process measures and complete the supplemental document (Appendix) to identify and describe your proposed process measures.*

   For DMPHs requiring infrastructure building metrics that are approved in the Prime Project Plan, 75% of PRIME funding for DY 11 will be based on the achievement of the approved DY 11 infrastructure building metrics through the final year-end report. Up to 40% of the total PRIME funding for DY12 will be based on the achievement of the approved DY 12 infrastructure building metrics through the mid-year and final year-end report. The proposed Process Measures should meet the following criteria:
   - *Specific*
   - *Measurable: Must be able to demonstrate progress throughout the duration of the process metric measurement period.*
   - *Evidence-based: Measures should have a strong evidence-base that can linked process to outcomes.*

Section 4.1 -- Domain 1: Outpatient Delivery System Transformation and Prevention

☒ 1.7 – Obesity Prevention and Healthier Foods Initiative

Sierra View Medical Center (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: SVMC selected this project after completing a multidisciplinary evaluation of community needs, resources and opportunities. Our 2016 Community Need Assessment ranked obesity as the second greatest health concern for Tulare County. Due to the high prevalence of obesity in both youth and adults, and the resultant health issues related to obesity, it was apparent that we must work to address this issue. As a result, we plan to build an infrastructure of programs and services that will provide for identification, knowledge transfer and linkages to resources that allow for self-management and healthy lifestyle choices both inside of the hospital and in the community

Planned Design and Implementation Approach:

- *Population Identification*: SVMC will work to place the necessary flags within our EHR that will help to identify those who are within the target population. We will also embed as many auto referral queues as able so as to ensure a streamlined referral process. We expect to complete this process DY11.

- *Care Pathway*: In DY11 and into DY12, the task force will develop and refine care pathways, in line with national standards, that focus on patient empowerment and program linkages.

- *Patient Tracking:* In DY12, we will develop a tracking mechanism for patient follow-up in adherence to the established care path.

- *Nutritional and Physical Counseling:* Explore alternative approaches to nutritional and physical counseling for patients through expanded provider agreements and placement of nutrition personnel in key patient-service settings. We being work on this task in DY11 and continue into DY12.

- *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. We plan on developing and submitting this plan DY12.

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

Target Population*:* The portion of the project having to do with obesity screening/ referral and nutritional counseling will focus on the adult and pediatric/adolescent Medi-Cal population accessing care at our hospital service sites. For the healthier hospital food initiative, we will target all patients, guests and employees who visit our hospital's campus 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 dietary offerings and prevention and screening for obesity. The targeted focus of Project 1.7 will support the long-term vision of SVMC to improve patient care through reductions in obesity and overweight levels in

our community. We anticipate these reductions will be due to the work of our facility to educate, track, treat and prevent causes of obesity through the PRIME program and beyond. This project will improve the health of the target population through the use of prevention, screenings and intervention for obesity and, ultimately, obesity related diseases.

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

Check, if applicable	Description of Core Components
Applicable	**1.7.10** Prepare for and implement the Partnership for a Healthier America's Hospital Healthier Food Initiative.

Please complete the summary chart:

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

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

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

Sierra View Medical Center (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*:* In 2015, SVMC had 92 Medi-Cal patients that readmitted 158 times. The most common readmission diagnoses were for chronic conditions, including Diabetes, COPD, Congestive Heart Failure, and Renal conditions. Common reasons, as reported by patient, for readmissions were: I couldn't fill my medication, I didn't know what medication to take, and I don't have a doctor. These challenges can be overcome through successful implementation of this PRIME project.

Planned Design and Implementation Approach: SVMC will convene a multidisciplinary workgroup in DY11 to design, implement, and monitor the program using rapid-cycle improvement methods.

- *Program GAP Analysis*: Evaluate current discharge planning/case management program and processes. Review best practice models and select a process that supports project goals. Conduct a gap analysis to determine required program enhancement/redesigns to align with selected model. This will be completed in DY11.

- Referral Processes: Develop referral process to include pre-established criteria to identify patients appropriate for the program. Seek to automate the process to include flags in the EHR and auto referral where possible. This will be completed in DY12.

- Clinical Pathways& Tools: Develop/refine care pathways. Care documentation and patient education tools will be developed with sensitivity to language and cultural needs. This will be completed DY12.

- Support Services: Develop a database/catalogue of community resources and a process to link patients to same. Develop processes that ensure patients are linked to the available community services. This will be completed in DY12.

- Care Team: Develop a care transitions team with case load ratios. Develop a workforce plan to reflect our approach to hire, train and/or retrain staff as needed. This will be completed in DY12.

- IT/EHR: Evaluate current EMR capability against the PRIME requirements (templates, risk stratification, auto referrals, and metrics) and address any gaps. This work will begin in DY11 and be completed 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: We expect that all Medi-Cal inpatients at SVMC will benefit from this PRIME project. However, we plan on a tiered approach to implementation where we will initially begin our work with a defined cohort group and will eventually expand to include all Medi-Cal patients.

Vision of Care Delivery: Utilizing a multi-disciplinary team, this project addresses whole person care. It serves to identify gaps in care, ensures patients are empaneled into a medical home and linked to appropriate community resources. It also promotes accurate and successful medication adherence. All of these interventions will help to ensure a more successful post-acute care environment were the patient will have an increased likelihood to successfully self-manage their health in the community. Doing so will decrease the number of readmissions and emergency room visits and 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	**2.2.1** Develop a care transitions program or expand a care transitions program to additional settings (e.g., emergency department), or to additional populations, using or adapting at least one nationally recognized care transitions program methodology.
Applicable	**2.2.2** Establish or expand on a system to track and report readmission rates, timeliness of discharge summaries, and other transition processes, and investigate system-specific root causes/risk factors for

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

Check, if applicable	Description of Core Components
	• Written transition care plan for patient and caregiver. • Timely communication and coordination with receiving practitioner. Community-based support for the patient and caregiver post hospitalization focusing on self-care requirements and follow-up care with primary and specialty care providers.
Not Applicable	**2.2.8** Engage with local health plans to develop transition of care protocols that ensure: coordination of care across physical health, substance use disorder and mental health spectrum will be supported; identification of and follow-up engagement with PCP is established; covered services including durable medical equipment (DME) will be readily available; and, a payment strategy for the transition of care services is in place.
Applicable	**2.2.9** Demonstrate engagement of patients in the design and implementation of the project.
Not Applicable	**2.2.10** Increase multidisciplinary team engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on care model.
Applicable	**2.2.11** Implement a system for continual performance feedback and rapid cycle improvement that uses standard process improvement methodology and that includes patients, front line staff and senior leadership.

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

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

Rationale: In 2015, SVMC had a total of 92 Medi-Cal patients that readmitted 158 times with chronic disease related diagnosis being the most frequent (HF, COPD and diabetic related complications). 72% of those readmitted had no MD follow-up within 30 days post discharge. Poverty, language barriers and lack of primary care access are all contributing factors to poor health management and resultant readmissions and ED over-utilization.

Design and Implementation Approach: SVMC will convene a multidisciplinary workgroup in DY 11 to design, implement, and monitor the program.

- *Referral Processes*: Develop referral process to the Care Management Program. The referral process will include pre-established criteria which identify patients appropriate for the program. Seek to automate the process as able to include flags in the EHR and auto referral where possible. This work will begin in DY11 and be completed in DY 12.

- *Clinical Pathways& Tools*: Develop/refine care pathways, in line with best practices, for chronic disease management to include a tiered approach to service delivery. Care documentation and patient education tools will be developed with sensitivity to language and cultural needs. This work will begin in DY11 and be completed in DY 12.

- *Support Services*: Investigate and develop a robust database/catalogue of community resources and a process to link patients to same. Develop processes that ensure patients are linked to the available community services. This work will begin in DY11 and be completed in DY 12.

- *Care Team*: Develop a multidisciplinary care team. Develop a workforce plan to reflect our approach to hire, train and/or retrain staff as needed. This work will begin in DY11 and be completed in DY 12.

- *IT/EHR*: Evaluate current EMR capability against the PRIME requirements and address any gaps. This work will begin in DY11 and be completed 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 prevalence of diabetes in our service area is significant. In calendar year 2014, SVMC serviced a total of 46,498 unique patients of which 11.2% or 5,248 had a diabetic related condition. While we expect to establish our target population as part of our planning activities, our focus will be on Medi-Cal patients who have diabetes and three other chronic conditions given the impact on and need in our community

Vision for Care Delivery: This project will be designed to work collaboratively with patients and their PCPs in achieving and maintaining optimum patient health and avoiding unplanned interventions. Patients will experience timely access to high quality,

focused interventions. This program will include improvements to be patient centric, expand the use of non-physician care team members, and implement alternatives to face-to-face patient-provider encounters and engages in population health management strategies. We will also provide resources to PCPs to increase their capacity to care for complex patients. As a culturally and linguistically sensitive complex care management program, SVMC will provide access to education, care coordination, monitoring and supportive services that will empower this vulnerable population with the necessary tools/services/information to take control of their health thus decreasing the likelihood of disease progression and/or complications resulting in readmissions or emergency room visits.

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

Check, if applicable	Description of Core Components
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.
Applicable	**2.3.10** Implement technology-enabled data systems to support patients and care teams throughout the care management program including patient identification, pre-visit planning, point-of-care delivery, care plan development and population/panel management activities.
Applicable	**2.3.11** Implement a data-driven system for rapid cycle improvement and performance feedback to address quality and safety of patient care, which includes patients, front line staff and senior leadership.

☒ 2.7 – Comprehensive Advanced Illness Planning and Care

Sierra View Medical Center (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: Access to palliative care is limited. Tulare County providers were assessed as only meeting 2% of its estimated need for palliative care compared to the 18% estimated in Fresno County. SVMC had only 41 documented end -of-life discussions between the family and doctor between March and July of 2015. Only 477 Advanced Directives were received from a total of 46,498 unique patients. This project will allow us to address this gap.

Planned Design and Implementation Approach: SVMC will convene a multidisciplinary workgroup to design, implement, and monitor the program in DY 11.

- *GAP Analysis*: Identify and evaluate processes/programs currently available to patients. Review best practice models and select a process that supports project goals. This work will begin in DY11 and be completed in DY 12.

- *Referral Processes*: Develop referral process including pre-established criteria to identify patients appropriate for program. Seek to automate process to include flags in the EHR and auto referral. This work will begin in DY11 and be completed DY 12.

- *Clinical Pathways & Tools*: Develop/refine care pathways in alignment with selected model. Care documentation and patient/family education tools will be developed with sensitivity to language and cultural needs. This work will begin in DY11 and be completed DY 12.

- *Support Services*: Develop a robust database/catalogue of community resources. Develop processes that ensure patients are linked to available community services. This work will begin in DY11 and be completed DY 12.

- *Care Team*: Develop a palliative care team and a workforce plan to reflect approach to hire, train and/or retrain staff. Develop educational programs for providers and front line staff. This work will begin in DY11 and be completed DY 12.

- *IT/EHR*: Evaluate current EMR capability against the PRIME project requirements and address any gaps. This work will begin in DY11 and be completed DY 12.

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

Target Population: We expect that all seriously ill patients at SVMC will benefit from this PRIME project. However, we plan on a tiered approach to implementation where we intend to begin this work with a defined cohort group of Medi-Cal patients and expand to others. The cohort group will be defined in DY11 but will include Medi-Cal patients with serious illnesses such as cancer, dementia and ESRD.

Vision for Care Delivery: Palliative care services at SVMC will help patients to manage their conditions, navigate the medical system and improve their quality of life. Our approach will orient and encourage both providers and patients to consider palliative care as a normal and acceptable adjunct to care. Through education and caring discussions, care will transfer into a patient centric model were choices will be discussed and decisions honored. Studies have demonstrated that most do not wish to die in a hospital but instead in the familiar surroundings of their home. Implementation of this program will allow for a patient's wishes for end of life care to be known and honored. As a result, these patients will not be subject to numerous futile and costly interventions frequently experienced with hospitalization in the last few days of life. As such, we expect to see a reduction in emergency department visits and acute admissions for this population.

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.
Not Applicable	**2.7.3** Implement, expand, or link with, a Primary Palliative Care training program for front-line clinicians to receive basic PC training, including

Check, if applicable	Description of Core Components
	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 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 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 $ 9,400,000
- DY 12 $ 9,400,000
- DY 13 $ 9,400,000
- DY 14 $ 8,460,000
- DY 15 $ 7,191,000

Total 5-year prime plan incentive amount: $ 43,851,000

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.	Establish PRIME Project Teams, including data documentation teams	• Obtain Senior Leadership support • Schedule and conduct team orientation • Update Population Health Committee Charter • Establish regular meeting schedule • Determine the necessary skills sets of the people required to analyze and develop required reports and EHR templates to support PRIME projects • Craft proposed membership to team • Present to and obtain Senior Leadership support • Schedule and conduct team orientation to PRIME	1.7, 2.2, 2.3, 2.7	January 1, 2016-June 30, 2016
2.	Complete workforce gap analysis to determine staff that needs to be hired, redeployed, and retrained to implement the new program	• Develop job descriptions for staff/positions as identified to include care navigator • Develop a workforce plan to reflect our approach to hire, train and/or retrain staff as needed • Develop training material for new hires • Staff to be trained include the Director of Education, eight Nursing Directors, eight Nursing Managers, eight Case Managers, and eight Social Services staff.	1.7, 2.2, 2.3, 2.7	January 1, 2016-December 31, 2016
3.	Establish PRIME reporting structure within the organizational framework and	• Review options (i.e. place within existing depts. or create new PRIME dept.)	1.7, 2.2, 2.3, 2.7	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
	develop budgets for each	• Meet with CFO & Financial Planning Director for final decision • Obtain necessary dept. numbers and required GLs. • Convene project teams • Draft budgets • Submit for approvals		
4.	Establish mechanism for patient engagement in the design of the programs	• Modify Population Health Committee membership (charter) to include patient representative. • Define how patient representative will be selected • Initiate selection process • Select and orient to role	1.7, 2.2, 2.3, 2.7	January 1, 2016-June 30, 2016
5.	Define target population(s)	• Convene project team with Data/Documentation task force rep • Discuss metrics and patient factors associated with a higher probability of being impacted by programs/projects • Define target populations	1.7, 2.2, 2.3 2.7	January 1, 2016-June 30, 2016
6.	Research and select care path(s)	• Convene a work group • Research/review and agree upon best practices/evidenced based guidelines • Develop a draft care plan(s) • Seek appropriate committee approvals • Work with data/ documentation team to integrate/embed/automate plan by developing a module/template • Develop a tracking mechanism for patient follow-	1.7, 2.2, 2.3, 2.7	January 1, 2016-June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		up in adherence to the established care path • Develop staff training on use of care paths • Implement care path processes in EMR • Staff to be trained include the Director of Education, eight Nursing Directors, eight Nursing Managers, the Director of Pharmacy, eight Social Service employees, and eight Case Managers.		
7.	Determine the minimum requirements needed for electronic/ EMR scheduling of patient encounter and documenting the care	• Conduct an EMR gap analysis • Develop plan to address GAPS (software update or new module purchase) • Implement solution	1.7, 2.2, 2.3, 2.7	January 1, 2016-June 30, 2017
8.	Design method to Collect baseline data including any associated disparities related to race, ethnicity or language need	• Convene Data/ Documentation task force • Analyze metric n/d, inclusion/exclusion requirements • Determine GAPS in current data reporting capabilities and required • Determine system capabilities in terms of addressing GAPS • Develop plan to close gaps • Implement plan • Test plan and make any necessary modifications	1.7, 2.2, 2.3, 2.7	July 1, 2016-June 30 2017
9.	Develop processes to provide recommended BMI screening services in line with national standards	• Convene work group to establish work flows • Review established policies	1.7	July 1, 2016 -June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Draft/revise policies in support of process/workflow implementation • Seek appropriate committee approvals for polices • Train staff on processes and workflow • Staff to be trained include the Director of Food Services, six Dieticians, eight Case Managers, and eight Social Workers.		
10.	Establish electronic/ automated functionality to support clinical decision in the provision of targeted services	• Convene project team • Define required functionality of system • Conduct a gap analysis of existing software • Develop plan to address GAPS (software update or new module purchase) • Implement solution	1.7, 2.7	July 1, 2016-June 30, 2017
11.	Develop and implement methodologies for improving receipt of targeted services, reducing associated disparities, and improving population health	• Convene social workers/ discharge planner/case workers from facility to brainstorm and list all presently know resources • Conduct internet research to expand list of resources • Contact local county health agencies for expanded resources • Convene regular meetings with stakeholders to address this issue	1.7, 2.2, 2.3, 2.7	July 1, 2016-June 30, 2017
12.	Identify community resources for patients to receive and create linkages with and connect/refer patients to same	• Convene social workers/ discharge planner/case workers from facility to brainstorm and list all presently known resources. • Conduct internet research to expand list of resources	1.7, 2.2, 2.3, 2.7	July1, 2016-June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Determine the scope of social needs linkage to be provided • Determine need for a social needs data base a. Minimum requirements b. Vendor option c. Selection process d. Implementation • Arrange for and establish a Community based Organization (CBO) Collaborative • Develop a database/catalogue of community resources and a process to link patients to same. • Develop processes that ensure patients are linked to the available community services.		
13.	Integrate PRIME into our system for performance management and continual 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 • Collaborative build a PI dashboard • Establish a reporting/ monitoring cycle for projects • Develop performance feedback and rapid cycle improvement initiatives policies and procedures	1.7, 2.2, 2.3, 2.7	January 1, 2017-June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Present dashboard at Population Health Committee for review and action. • Implement performance feedback and rapid cycle improvement process		
14.	Develop plan for nutritional and physical activity counseling	• Convene the project team and develop a plan to address counseling • Research models and approaches to nutritional and physical activity counseling • Explore alternative approaches to nutritional and physical counseling through expanded provider agreements and placement of nutrition personnel in key patient-service settings • Select model/approach	1.7	July 1, 2016-December 31, 2016
15.	Select or adapt at least one nationally recognized care transitions program methodology	• Convene project team • Research best practice models • Select/adapt a model • Evaluate current DP process against selected model • Define the GAPS	2.2	July 1, 2016-December 31, 2016
16.	Expand/enhance our system on tracking and reporting readmission rates, timeliness of discharge summaries, and establish a methodology to investigate system-specific root causes/risk factors for readmission,	• Conduct a gap analysis of existing software • Develop plan to address GAPS (software update or new module purchase) • Implement solution	2.2	July 1, 2016-June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
	information to identify the key causes of readmissions			
17.	Develop a process, including utilization of data and information technology, to reliably identify hospitalized patients at high-risk for readmission	• Convene project team • Define required functionality of system • Conduct a gap analysis of existing software • Develop plan to address GAPS (software update or new module purchase) • Draft and finalize process for identifying high-risk patients for readmission • Train staff on the process • Implement process • Staff to be trained include the Director of Pharmacy, one Med Reconciliation employee, eight Case Managers, twelve Charge Nurses, and eight Social Workers.	2.2, 2.3	July 1, 2016-June 30, 2017
18.	Develop standardized workflows to ensure accuracy of medication list at time of discharge	• Convene project team • Review current medication reconciliation process • Evaluate GAPS • Establish plan to close • Train staff on the workflows • Staff to be trained include twelve Charge Nurses, eight Case Managers, and eight Social Workers.	2.2	July 1, 2016-June 30, 2017
19.	Develop process to ensure reconciliation of DC medication list to current medication	• Convene project team • Review current medication reconciliation process • Evaluate GAPS and identify plans to close GAPS • Train staff on the process • Staff to be trained include twelve Charge Nurses, eight	2.2, 2.3	July 1, 2016 -June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		Case Managers, and eight Social Workers.		
20.	Develop processes for care transitions	• Convene project team • Evaluate current discharge planning/case management program and processes • Review best practice models and select a process that supports project goals • Conduct a gap analysis to determine required program enhancement/redesigns to align with selected model	2.2	January 1, 2016- June 30, 2016
21.	Develop a referral process for care transitions and complex care coordination	• Develop referral process to include pre-established criteria to identify patients appropriate for the program • Seek to automate the process to include flags in the EHR and auto referral where possible	2.2, 2.3	July 1, 2016 – June 30, 2017
22.	Develop care teams for care transitions and complex care coordination	• Develop a care transitions team with case load ratios • Develop a complex care coordination team with case load ratios • Develop a workforce plan to reflect our approach to hire, train and/or retrain staff as needed • Staff to be trained include eight Case Managers, and eight Social Workers.	2.2, 2.3	July 1, 2016 – June 30, 2017
23.	Determine the minimum requirements needed for the creation of a data registry (population health stratification of high risk patients)	• Conduct a gap analysis of existing software • Develop plan to address GAPS (software update or new module purchase) • Implement solution	2.2, 2.3	July 1, 2016- June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
24.	Develop standardized process for transitioning patients to sub-acute and long term care facilities	• Convene project team • Review process • Evaluate GAPS • Establish plan to close • Train staff on the process • Staff to be trained include eight Case Managers, eight Social Workers, the Director of Sub-Acute, Medical Director of Sub-Acute, Manager of Critical Care Services, and Director of Critical Care Services	2.2	July 1, 2016 -June 30, 2017
25.	Develop mechanisms to support patients in establishing primary care for those without prior primary care affiliation	• Convene project team • Review frequency by which patients are discharge without primary care assigned • Analyze for trends • Evaluate causation • Identify access points • Develop implementation plan for linkage/referral	2.2	July 1, 2016 -June 30, 2017
26.	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	• Convene team • Review current process • Evaluate current tools • Evaluate referral network • Identify gaps • Establish plan to close gaps • Train staff on the process • Staff to be trained include eight Case Managers, eight Social Workers, and six Internal Medicine Hospitalists	2.2	July 1, 2016- June 30, 2017
27.	Develop process/program to support family/patient post-discharge focusing on self-care requirements and follow-up care with	• Convene work group • Evaluate current patient education tools and discharge instruction • Evaluate current care transition tools against selected best practice models/tools	2.2	July 1, 2016 -June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
	primary and specialty care providers	• Determine gaps • Modify or adopt new tools • Educate family/patient on self-care program and process • Train staff on tools and discharge instructions		
28.	Establish a mechanism for timely communication and coordination with receiving practitioner	• Convene work group • Evaluate current process • Identify gaps • Establish action plan to close gaps	2.2, 2.3	July 1, 2016-June 30, 2017
29.	Identify/adopt a nationally recognized complex care management program methodology	• Convene project team • Research best practice models • Select/adapt a model • Evaluate current process against selected model • Define the GAPS • Craft action plan to close gaps	2.3	July 1, 2016-December 31, 2016
30.	Establish data analytics systems using clinical data sources, utilization and other available data to enable identification of high-risk/rising risk patients for targeted complex care management interventions, pre-visit planning, point-of-care delivery, care plan development and population/panel management activities	• Convene project team • Define required functionality of system • Conduct a gap analysis of existing software • Develop plan to address GAPS(software update or new module purchase)	2.3	July 1, 2016-June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
31.	Develop a multi-disciplinary care team model to which each participant is assigned, that is tailored to the target population and whose interventions are tiered according to patient level of risk	• Define care team based on care path • Define estimated length of touch point • Define case load	2.3	January 1, 2017-June 30, 2017
32.	Develop training and educational calendar to ensure that the complex care management team demonstrates effective team functioning and care management skill sets	• Research available educational resource tools • Develop educational tool/programs/if necessary • Develop training calendar • Implement staff training on complex care management • Staff to be trained include the Director of Pharmacy, eight Case Managers, eight Social Workers, and the Director of Education	2.3	July 1, 2016-June 30, 2017
33.	Implement evidence-based practice guidelines to address risk factor reduction and referral to treatment as well as to ensure appropriate management of chronic diseases:	• Establish screening guidelines to be used (i.e. standardized patient assessments, evaluation tools). • Identify available treatment options within community • Develop referral mechanism • Develop/source educational materials that are consistent with cultural, linguistic and health literacy needs of the target population. • Train staff on the screening tools and guidelines • Staff to be trained included the Director of Pharmacy, the Director of Critical Care	2.3	July 1, 2016-June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		Services, Director of Med/Surg, four Nurse Managers, eight Case Managers, eight Social Workers, six Internal Medicine Hospitalists.		
34.	Develop systems and ensure system navigation and 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 our authority, and promote adherence to medications	• Develop a comprehensive assessment tool • Train care coordinator(s) in the use of the tool • Develop a referral mechanism to care members that will provide support to the patient and linkage to resources • Establish a tiered follow up process to promote patient adherence to services. • Establish a tiered follow up process to promote patient adherence to prescribed medications • Staff to be trained include the Director of Pharmacy, Director of Critical Care Services, Director of Med/Surg, eight Case Managers, and eight Social Workers	2.3	July 1, 2016 -June 30, 2017
35.	Identify available clinic site	• Evaluate compliance with specific building codes • Determine required building modification to align with specific licensing requirements and codes (as applicable). • Identify Architect for project if needed • Complete specific application to city/state/federal • Make required building modification	2.3, 2.7	July 1, 2016- June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Identify potential sites for rural health clinics to be established. • Explore co-management opportunities with FQHC partner • Explore the options of establishing a primary care urgent care		
36.	Develop comprehensive advance care planning processes and improve implementation of advance care planning with advanced illness patients.	• Convene project team • Evaluate current process • Outline the gaps • Develop training to staff and providers • Incorporate triggers/flags /prompts in system to identify patients in need of advanced planning • Incorporate triggers/flags /prompts in system to identify patients who have an established plan. • Staff to be trained include the Director of Pharmacy, Director of Renal Services, eight Case Managers, and eight Social Workers.	2.7	July 1, 2016-June 30, 2017
37.	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	• Convene palliative project team • Research best practices for symptom relief (pain management) • Develop draft protocol • Establish mechanism for use • Obtain committee approvals • Incorporate into EHR order set • Educate physician and staff on the protocol	2.7	July 1, 2016-June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
38.	Establish training for Improve completion of Physician Orders for Life-Sustaining Treatment (POLST) with eligible patients and participation in in the state-wide POLST registry	• Convene a work group • Evaluate current level of knowledge of process • Research POLST registry functionality • Craft training material and schedule to address deficits • Assess effectiveness of training	2.7	July 1, 2016-June 30, 2017
39.	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	• Assess current available agencies that provide palliative care in the home. • Determine breath of capabilities • Research current palliative collaboratives. Determine available programs and resources • Establish referral mechanism	2.7	January 1, 2016-June 30, 2016
40.	Establish process of written communication to receiving site of the presence of an advance care plan 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	• Convene a work group • Assess current practice • Determine gaps to compliance • Craft plan to address gap • Implement plan	2.7	July 1, 2016-June 30, 2017
41.	Engage staff in trainings to increase role-	• Research available educational resource tools and/or programs	2.7	July 1, 2016-June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
	appropriate competence in palliative care skills, with an emphasis on communication skills	• Develop tool/programs if necessary • Develop training calendar		