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	Ventura County Health Care Agency/Ventura County Medical Center
Health Care System Designation(DPH or DMPH)	DPH

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.

The Ventura County Health Care Agency (VCHCA) is located in Ventura County, California, the 13th largest of California's 58 counties by population. The county's health care needs and disparities are summarized as follows:

Physical Health:

- *Diabetes:* More than half of adults either have diabetes (6%) or pre-diabetes (47%).[1] With a death rate 1.5 times that of other races/ethnicities, 9% of Latinos have diabetes.[2]
- *Heart Disease and Stroke:* Approximately 25% of residents have been diagnosed with high blood pressure and 31.4% over 65 years of age have heart disease. The leading cause of premature death for most age and race/ethnic groups in Ventura County is coronary heart disease.[3]
- *Cancer:* Among males, the most commonly diagnosed cancer is prostate cancer, yet 78% of Latino men 40 years and older have never received a prostate-specific antigen test. The death rate from breast cancer is 21.3 per 100,000 residents compared to 20.7 for California as a whole.[4] See cause of death statistics in Table 1.
- *COPD:* Of the 28,516 residents with COPD, approximately 10,900 are low-income. COPD/respiratory distress caused 8.7% of all ED encounters and 4.7% of all inpatient admissions at Ventura County Medical Center (VCMC) in 2015, a rate higher than other California hospitals.[5]

Behavioral Health: Among VCMC admissions, 12.6% were for mental health disorders. California death statistics show that the suicide rate among county residents (11.6) and drug-induced death rate (13.9) exceed that of California (10.2 and 11.1, respectively).[6] Alcohol-impaired driving deaths in 2013 were 33% of all driving deaths, compared to 29% for California.[7]

Health Disparities: More than 22% of residents are foreign-born and 41.5% are Latino,[8] a population disproportionately affected by cardiovascular disease, cancer, diabetes, and asthma. Nearly 62% of VCHCA's patient population is Latino. The overall poverty rate is 11.1%, but 27.6% of seniors and 23.7% of persons younger than 25 live in poverty.[9] Both of these populations have a higher risk for multiple health disparities

due to reduced access to health care.[10] The infant mortality rate among Latino women (4.9 per 1,000 live births) exceeds that of California (4.7) and the Ventura County rate among all races/ethnicities (4.6).[11]

Coverage: Approximately 15.2% of residents have no health insurance, and 67% of VCHCA's patients are uninsured or on Medi-Cal. Moreover, Ventura County Latinos had the lowest rate of health insurance – just 74.2% compared to 91.9% of non-Latino whites.[12]

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.

Per Capita Income: Per capita income in Ventura County is $33,308, compared to $28,555 for California.[13] This differential is primarily due to the high cost of living in the county. The Cost of Living and Cost of Housing Indexes in Ventura County are 163.50 and 276, compared to 100 for the U.S., which increases the financial pressure on residents.[14] Although the median household income in Ventura County was $77,335,[15] 67.31% of patients served by VCHCA are on Medi-Cal with incomes below 138% of the Federal Poverty Level (FPL). Overall, the county unemployment rate was 5.1% in February 2016.[16]

Age: The population is slightly older than the state overall, with an average age of 36.9 years, compared to 35.6 statewide.[17] The age breakdown is as follows:

- 0-18 years (25.7%)
- 19-64 years (62.6%)
- 65 and over (11.7%)

Race/Ethnicity: Ventura County is home to 846,178 residents, comprised of 47.3% white, 41.5% Latino, 7.3% Asian, 2.2% black or African American, and 1.7% other races/ethnicities.[18] VCHCA's safety-net population is 61.3% Latino, 36.7% white/non-Hispanic, and 2.0% other races/ethnicities or unknown.

Primary Language: Although English is the primary language spoken in Ventura County (61.8%), 38.2% of the Ventura County population over the age of 5 spoke a language other than English at home in 2014, and 30.2% of the population spoke only Spanish at home.[19]

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.

Health Care System: VCHCA is a fully-integrated, comprehensive designated public health care system with two hospitals, 41 clinics including eight urgent care sites (see Attachment 1 and Table 2), Ventura County Behavioral Health Department (VCBH) with

six mental health and substance abuse clinics, Ventura County Public Health Department (VCPH) with two clinics and multiple population health programs, Emergency Medical Services, Medical Examiner, and the Ventura County Health Care Plan, a county-owned Health Maintenance Organization.

License Category: VCMC and Santa Paula Hospital are licensed by the California Department of Health Facilities as general acute care hospitals.

Beds: VCMC is a 180-bed hospital, with an additional 43-bed Inpatient Psychiatric Unit. Santa Paula Hospital has 49 beds. During 2015, the average length of stay for acute care was 4.5 days, beds had a 73.5% occupancy rate, and 85% of the beds were staffed.

Clinics: VCHCA has 19 primary care FQHCs and 14 clinics providing both primary and specialty care services. These clinics provide more than 530,000 outpatient visits annually and are located in nine geographically dispersed communities. They are served by 693 physicians and 87 Licensed Independent Practitioners (LIPs).

Specialties: VCHCA clinics provide 60 specialty services (see Table 3). VCMC also offers high-quality specialty services, including its renowned UCLA-affiliated Family Medicine Residency program (ranked #2 nationally),[20] Neonatal ICU, Level II Adult Trauma Center, and Palliative Care Program.

Payer Mix: The population served by VCMC and VCHCA ambulatory care in fiscal year 2014-15 was approximately 67.9% Medi-Cal, 17.9% managed care/commercial insurance, 10.0% Medicare, and 4.2% uninsured.

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.

Current Resources: VCHCA is in the process of completing Meaningful Use Stage 2 Electronic Health Record (EHR) expansion strategies and preparing for transition to Stage 3. VCHCA is working toward software improvements designed to facilitate care coordination, including data warehousing, disease registries, care management tools, and enhancements to clinical decision support. The Gold Coast Health Plan, Ventura County's Medi-Cal managed care plan, provides monthly clinical performance and patient outcome reports with the ability to data mine for specific projects as needed. A team of health care informaticists and analysts at VCHCA are working to improve clinical work flow and establish pathways to pull reports for baseline data. Data will be monitored and shared with PRIME project champions, who will develop strategies to move projects forward through rapid cycle improvement methodologies. These resources will support PRIME clinical quality reporting requirements, by informing the system's baseline, then further expanding capacity to support quality improvement

strategies, data collection, and reporting.

Limitations/Barriers and Strategies to Overcome: The largest obstacle is VCHCA's current limitations to collect baseline and ongoing performance data, due to a shortage of data staff, disorganization of existing data and improper clinical workflows for accurate data collection. The need for informaticists and analysts with health care understanding has been addressed by the re-allocation of current staff to the PRIME Data Management Team. New positions will also be created to facilitate PRIME and other Waiver projects. The PRIME Data Management Team has assessed the availability, location, and accuracy of data that is currently available. The team is writing and validating reports to determine baselines from the EHR. Issues that are found with data input and organization are being catalogued. The Data Management Team will work with clinical staff to create input process maps for all metrics.

A comprehensive EHR improvement plan is a key piece of the overall clinical transformation. Informaticists and IT, administrative, and clinical staff will analyze the current EHR design, capabilities, and usage deficiencies in relation to the needs of the nine projects. New input methods and/or EHR features will be created to improve the robustness of ongoing data collection. A systematic, collaborative improvement process of design, implementation, education, and dissemination has been created to make and support EHR changes and workflow adaptations that will ensure better data collection while maintaining or improving workflow efficiency.

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 the ability to successfully perform under risk-based Alternative Payment Methodologies (APMs). This section of the Plan will be used to present each entity's overall goals and specific aims for PRIME. This section should also describe how these efforts will evolve over the course of the five years.

3.1 PRIME Project Abstract [No more than 600 words]

Please address the following components of the Abstract:

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

The County of Ventura Strategic Plan (2011-2016)[21] is the overarching authority driving VCHCA goals. Specifically, Area #4 Community Well-Being, Strategic Goal 1 states: *Achieve the Triple Aim, by providing quality healthcare in a patient-centered, integrated, equitable and efficient manner, improving the health of Ventura County residents.* PRIME goals align with and are designed to support the accomplishment of the county's strategic goals and the VCHCA mission, which will drive planning and implementation processes through the following goals:

Goal 1: Reduce health disparities by implementing evidence-based practices that transform VCHCA care for county residents.

Goal 2: Reduce cost by improving work flow practices and reducing avoidable utilization.

Goal 3: Optimize the use of health information technology (HIT) to enhance quality improvement efforts.

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.*

Aim 1: Strengthen physical, behavioral, and specialty health integration to more efficiently serve VCHCA patients.

Aim 2: Improve care coordination across service settings to improve the patient- centeredness of care and health outcomes, reducing duplicative services.

Aim 3: Reduce health inequities for all patients, especially those who are the most vulnerable.

Aim 4: Reduce inappropriate and over-utilization of resources through effective use of HIT, clinical practice guidelines, care coordination, Lean and PDSA[22] processes, and administrative oversight.

Aim 5: Improve quality improvement efforts through HIT upgrades designed to expand metric variables collected, improve functionality to inform data analytics, and strengthen rapid cycle improvement processes.

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;*

Goals and specific aims directly relate to specified projects, but many of the projects span multiple goals and aims. All projects have core components related to a comprehensive HIT development plan and Aim 5. Table 4 demonstrates how each project is aligned with one or more goals and aims.

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 nine projects interrelate, overall, because combined they are all components of a total system transformation designed to reach the 5-year vision (see 3.1.5). Many of the projects not only interrelate, but depend on other projects' implementation to be successful. For example, Project 1.3's care coordination initiative will support the standardization of Million Hearts chronic disease clinical management in Project 1.5. Project 2.3's complex care management strategies will need to be developed synergistically with care transitions in Project 2.2. All projects are interdependent, affecting system-wide changes, integrating care across settings, and coordinating care so that each project can operate optimally.

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.*

VCHCA's vision for PRIME at the end of five years is a system that provides the right care, in the right place, at the right time, every time. By building a coordinated, integrated care system or "medical neighborhood," VCHCA will undergo intense practice transformation, adopt new payment models, develop sophisticated data management processes, and adopt technologies to help patients and providers stay informed and connected. PRIME projects will improve health care quality and patient-centeredness, and reduce inefficiencies, fragmentation, and health inequities. The PRIME projects will result in advances that will affect this transformation on multiple levels:

- ***Clinical:*** Clinical advances will be implemented through physical, behavioral, and specialty care integration; improved care coordination; clinical practice guidelines; decision support; and patient-centered care.
- ***Population Health:*** Population health will be improved by implementing complex and chronic care management systems, population health intelligence platforms, risk stratification tools, patient engagement services, access to care improvement

strategies, and predictive analytics.

- ***Fiscal:*** Cost reductions will be realized by reduced inappropriate or over-resource utilization, improved population health management, and system-wide evidence-based practices, preventive health strategies, decision support, and training.
- ***Other Critical Outcomes:*** Improvements in HIT will effectively inform care providers about population health status, allowing for interventions informed by predictive analytics while providing needed data to drive quality improvement.

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.

System transformation that will be achieved by the proposed projects will meet community needs by specifically addressing the population health factors and health disparities identified in Section 2.1. Implementation of a Patient-Centered Medical Home (PCMH) model, disease registries, and care management tools will drive transformation and clinical integration. Physical and behavioral health integration will impact the incidence of morbidity and mortality related to behavioral health. Patients will be assessed at regular primary care appointments where mental health and substance use disorder issues will be identified early, impacting the progression of patients' conditions. This integration will also address needs of patients with diabetes, cancer, congestive heart failure, and COPD who have high rates of co-occurring depression.

Care coordination projects will improve health outcomes for the most vulnerable patients, including patients who are high utilizers of multiple systems and resources, patients transitioning out of inpatient care who are at risk of readmission, and foster children. The county's health disparities concerning disproportionate chronic diseases among Latinos will also be addressed by care coordination for complex conditions, clinical practice guideline implementation into HIT, and staff training. The high rate of cardiovascular disease will be addressed by the Million Hearts initiative strategies and care coordination for complex conditions. Complex care management, combined with effective care transitions, will improve health outcomes for at-risk patients who utilize VCMC for care. The VCMC Patient Blood Management program will implement evidenced-based American Association of Blood Banks (AABB) guidelines system-wide, reducing the risk of adverse reactions among transfused patients.

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 County of Ventura Strategic Plan (2011-2016)[23] drives VCHCA goals. Strategic Goal 1 (Section 3.1.1) is specifically aligned to PRIME and drives PRIME infrastructure planning. A new VCHCA Strategic Plan is currently in development and will include PRIME goals, aims, projects, and other 1115 Waiver initiatives. Many funding agencies currently monitor quality improvement goals related to their programs, such as National Quality Improvement Goals,[24] CMS Quality Strategy,[25] FQHC Section 330 goals, and National Committee for Quality Assurance (NCQA) goals based on HEDIS measures.

These and other goals align to PRIME projects, which will be enhanced to measure and monitor required metrics.

Monitoring and feedback mechanisms include EHR data reports, Gold Coast Health Plan's HEDIS reporting, electronic data warehouses, disease registries, and care management tools (Section 2.4.). Data-driven decision-making practices will be accomplished by integrating evidence-based clinical management guidelines into the EHR so that providers can access decision support information during the patient care process. EHR data improvements will enable multidisciplinary teams and administrative leadership to more effectively monitor clinical decision making and performance.

Organizational infrastructure that will be established will focus on planning for PRIME implementation, including analyzing system-wide gaps, assessing data system needs for baseline measurement, determining tasks/activities that must occur to achieve goals and specific aims, scheduling and analyzing work flow to ensure that all nine projects' tasks/activities progress in a timely manner and are synchronized, and developing a comprehensive implementation plan, including a complete analysis of EHR/data system needs to align with metric measurement.

Executive Leadership Support and Infrastructure for PRIME: Since the submission of the PRIME 5-Year Plan Application, the following specific steps have been taken to ensure that a closed loop communication and implementation plan are in place.

1. A unit for Population Heath Management and Clinical Integration, lead by a VCHCA Deputy Director, has been established to oversee all the various components of the Waiver. All infrastructure required for putting workflows in place to achieve PRIME Metrics, Core Components, conduct PDSA improvement cycles, and report progress will be coordinated through this unit. The unit's leadership team is comprised of a Medical Director, Performance Improvement and Quality, informaticists, and senior administrative leadership.

2. The Ventura County Board of Supervisors and the CEO have been informed of the PRIME projects' details. They will receive ongoing updates as necessary or required.
3. Quarterly meetings are scheduled with the Ventura County CEO's office to report progress and any barriers that need to be addressed.
4. Bi-weekly meetings are held with the VCHCA Director to report progress, obtain input, and receive support as needed.
5. A Waiver Integration and Oversight Committee (WIOC) comprised or senior leadership from the Ventura County CEO's office, VCHCA, Ambulatory Care, VCMC, Behavioral Health, Public Health, Human Services Agency, Finance, County Legal Counsel, and Informatics has also been established. The objective of this committee is to provide strategic guidance to meet Waiver requirements, develop and implement strategies for care delivery integration across all county care delivery systems, and develop plans for long term sustainability. WIOC will meet on a quarterly basis or as necessary to keep integration efforts on track.
6. A PRIME Data Management Team has been established within the Population Health Management and Clinical Integration unit to look at workflows, obtain provider and frontline staff feedback to ensure that core components/metrics implementation will not be disruptive to operations, but will become part of the normal workflow. This team meets on a weekly basis and will be the lead on establishing EHR workflows, conducting provider and support staff trainings, collecting data, analyzing and validating data, and producing end-user level reports for continuous improvement.
7. The Ambulatory Care Quality Team will lead monthly Ambulatory Care Quality Alliance (ACQA) meetings with the clinic staff to design, integrate, and implement PRIME projects. Each clinic will be represented by a provider champion, an EHR/data expert, and an operations manager who will ensure that pertinent PRIME implementation details are communicated at all levels at the clinics. Clinic staff will be divided into Working Groups comprised of 4-5 primary care clinics, with one team of specialty clinics. Best practices will be shared through this alliance, with ongoing bi-directional communication to address pitfalls and celebrate successes staff work together to improve patient outcomes.
8. Medical Directors of Ambulatory Primary and Specialty Care, VCMC, Performance Improvement and Quality for Ambulatory Care and VCMC, Behavioral Health and their administrative counterparts are all part of the nine PRIME project workgroups. Additionally, executive leadership from Public Health and Human Services Agency are also members of project workgroups.
9. Each of the PRIME projects has clinical and administrative champions who meet on a bi-weekly basis to discuss implementation strategies. The Deputy Director of Population Health Management and Clinical Integration and Manager for PRIME Data Management Team are present at each of these meetings to provide operational and technical guidance and input. This group also receives feedback from frontline staff to ensure that workflow changes are being communicated appropriately.

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.

An executive team comprised of clinical and administrative leaders from various county entities within VCHCA currently makes up the PRIME Advisory Committee, which will continue to drive transformation during the planning and implementation process. Regular committee meetings will engage other stakeholders for input/decision making, including beneficiaries, community providers of PRIME services outside of VCHCA, and business/community leaders. Beneficiaries are present on at least 11 committees within VCHCA that will be impacted by the projects (see Table 6). During the planning of projects, beneficiaries and VCHCA staff will be brought together in focus groups to review draft plans and comment on the needs of the patient population.

The Mixteco/Indigena Community Organizing Project (MICOP) and other stakeholders representing racial/cultural patient groups will review planned tasks/activities and service delivery to address whether cultural competency improvements are needed. Care coordinators and multidisciplinary teams will engage users of project services and their input will be included as part of the quality improvement process. Public engagement with multiple stakeholders will be accomplished through development of DHCS reports, Board of Supervisors presentations, website/newsletter descriptions of project development, and website/brochure listings of project services, as applicable.

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.

At least 60% of VCHCA PCPs speak Spanish and five PCPs speak Mixteco. Approximately 30% of the VCHCA PCPs are Latino. Among the VCHCA clinic support staff, 80% are Spanish speaking, 65% are Latino, and ten are Mixtecan. If a provider does not speak Spanish or Mixteco or one of the other languages available, clinic support staff is readily able to assist the provider by initiating a call to LanguageLine Solutions to ensure quality telephonic interpreting services in more than 200 languages. All VCHCA staff members participate in annual cultural competency training.

Planned PRIME efforts to ensure cultural competency include: cultural competency review of planned activities/interventions by MICOP and other stakeholders, English/Spanish translations of health education/program materials, and expanded staff training incorporating cultural competency factors.

Strategies to reduce healthcare disparities include: promotores outreach to isolated Latino/Mixteco communities for chronic disease testing, assignment of

bilingual/bicultural care coordinators for Latinos with complex needs and for care transitions, and enhanced health/risk assessment strategies.

Resources currently in place include: well-established outreach connections/programs through Public Health and other community organizations, a mobile primary care clinic that reaches isolated beneficiaries, and relationships with multiple culturally-focused community organizations that serve diverse communities in the county.

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.

PRIME sustainability will be accomplished through significant infrastructure investment, a shift from fee-for-service to value-based payments, reductions through a transformed and optimized system, continuous performance improvement, improved data analytics capabilities, and synchronized project implementation and operations. The PRIME plan will clearly outline sustainability activities, including: cost efficiency models that shift focus from episodic to preventive care; population health management methodologies emphasizing cost efficiency and clinical outcomes; developing alternative payment methodologies that incentivize non-traditional encounters; engaging patients and support structures to self-manage disease processes; engaging community organizations/leaders to combine resources to address morbidity indices; utilizing tele/digi health; expanding prevention efforts; and traditional forms of fundraising (i.e., grants and local fundraising efforts).

Change management will be implemented through PCMH methods,[26] rapid cycle improvement strategies, and organizational leadership that develops strategies to communicate and get staff acceptance by using the “Four Rs” of healthcare change: Reason, Result, Route, and Role. [27]

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.*

   3. Not applicable: Applicant is a DPH.

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

☒ 1.1 Integration of Physical and Behavioral Health (required for DPHs)

Rationale for Project: VCHCA outpatient clinicians recognize the need for a mechanism to comprehensively screen patients for behavioral health service needs. Many patients have physical health conditions associated with a high rate of co-morbidity and have a high rate of co-occurring depression and/or substance use disorders (SUD). For example, 25% of patients with adult onset diabetes[28] and 25% of patients with cancer[29] have depression. Twenty-seven percent of patients with depression also suffer from some form of substance abuse.[30] The integration of physical and behavioral health is needed to fully address the needs of patients with co-occurring physical and behavioral health conditions. Identifying these patients through early screening facilitates prompt intervention, which will reduce the cost of care and improve outcomes.

Planned Implementation Approach: VCHCA integration of physical/behavioral health will utilize the Four Quadrant Model for Clinical Integration.[31] Primary care clinics will administer PHQ-2 screening to adolescents and adults annually. Those who screen positive will receive PHQ-9 screening. Primary care clinics will also assess patients for alcohol and substance abuse using the SBIRT, AUDIT, and DAST screening tools.

Patients with anxiety, depression, or SUD will be provided appropriate interventions.

Interventions for mild-to-moderate conditions will be provided by PCPs and by behavioral health professionals integrated within the primary care clinic. These interventions will include individual and group counseling, education, cognitive therapy, nutrition and exercise counseling, and medication management in collaboration with a pharmacist. Patients with acute/severe conditions will be referred to the VCBH Department for more intensive interventions. Planned improvement in the coordination and quality of care through implementation of PCMH initiatives and robust communication protocols will align PCPs, behavioral health providers, and specialists to benefit patients (see Project 1.2). Primary care teams will be trained in the administration of the screening tools and referral and treatment protocols.

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

Target Population: The project target population includes all assigned managed Medi-Cal lives as well as those who have had at least two primary care encounters with VCHCA within the measurement year. Ventura County has a high prevalence of patients diagnosed with co-morbid chronic medical illnesses, psychiatric disorders, and SUD.

Vision for Care Delivery: This PRIME project will enable VCHCA to accomplish key objectives focused on the Triple Aim. Training primary care teams to implement screening tools will allow practices to identify patients who need early intervention. Ensuring that all primary care patients have access to behavioral health assessments will enable VCHCA to avoid costly emergency room/crisis intervention services, referrals to care settings for services that could be provided at a lower level of care and an escalation of problem acuity because a patient was not routinely assessed at the PCP level. Interventions provided in the outpatient setting, both within primary care and behavioral health settings, will improve rapid access and treatment for patients needing behavioral health services. Implementation of the NCQA PCMH model[32] of care will provide system-wide transformation that specifically provides improvements in all three Triple Aim elements (see Project 1.2). Fine-tuning the overall behavioral-physical health integration model through additional screenings, care coordination, follow-up, and quality improvement processes will result in improved patient satisfaction, care quality, and patient outcomes.

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

Check, if applicable	Description of Core Components	
Applicable	**1.1.1**	Implement a behavioral health integration assessment tool (baseline and annual progress measurement)

Check, if applicable	Description of Core Components
Applicable	**1.1.2** Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration, the Collaborative Care Model, or other Integrated Behavioral Health (IBH) resources from SAMHSA)
Applicable	**1.1.3** Integrate appropriate screening tools and decision support into the emergency department (ED) to ensure timely recognition of patients with mental health and substance use disorder problems. Enhanced access to primary care and/or to behavioral health specialists will be integrated into discharge planning for these patents. Use of 24-7 care navigators (e.g., Community Physician Liaison Program) may be used to support linkages to primary care providers (PCPs), mental health (MH) and substance use disorder (SUD) specialists and behavioral health and other community services through the discharge process.
Applicable	**1.1.4** Integrate physical and behavioral health, either through implementation of a new program or an expansion of an existing program, from pilot sites to hospital and health system primary care sites or from single populations to multiple populations (e.g., obesity, diabetes, maternal, infant, and child care, end-of-life care, chronic pain management).
Applicable	**1.1.5** Patient-Centered Medical Home (PCMH) and behavioral health providers will: • Collaborate on evidence based standards of care including medication management and care engagement processes. • Implement case conferences/consults on patients with complex needs.
Applicable	**1.1.6** Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families.
Applicable	**1.1.7** Ensure systems are in place to support patient linkages to appropriate specialty physical, mental and SUD services. Preventive care screenings, including behavioral health screenings (e.g., PHQ-2, PHQ-9, SBIRT), will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including the provision of brief interventions (e.g., motivational interviewing techniques) to ensure access for further evaluation and treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.

Check, if applicable	Description of Core Components
Applicable	**1.1.8** Provide cross-systems training to ensure effective engagement with patients with MH/SUD conditions. Ensure that a sufficient number of providers are trained in SBIRT and/or in other new tools used by providers to ensure effectiveness of treatment.
Applicable	**1.1.9** Increase access to Medication Assisted Treatment (MAT) for patients with alcohol and opioid addiction to assist in stabilizing their lives, reducing urges or cravings to use, and encourage greater adherence to treatment for co-morbid medical and behavioral health conditions. For alcohol use disorders these medications include naltrexone, acamprosate, and disulfiram. For opioid addiction, medication assisted treatment (MAT) includes maintenance treatment with methadone and buprenorphine.
Applicable	**1.1.10** Ensure the development of a single treatment plan that includes the patient's behavioral health issues, medical issues, substance abuse, social and cultural and linguistic needs. This includes incorporating traditional medical interventions, as well as non-traditional interventions such as gym memberships, nutrition monitoring, healthy lifestyle coaching, or access to culturally and linguistically appropriate peer-led wellness and symptom management groups.
Applicable	**1.1.11** Ensure a culturally and linguistically appropriate treatment plan by assigning peer providers or other frontline worker to the care team to assist with care navigation, treatment plan development and adherence.
Applicable	**1.1.12** Ensure that the treatment plan: • Is maintained in a single shared Electronic Health Record (EHR)/ clinical record that is accessible across the treatment team to ensure coordination of care planning. • Outcomes are evaluated and monitored for quality and safety for each patient.
Applicable	**1.1.13** Implement technology enabled data systems to support pre-visit planning, point of care delivery, care plan development, population/panel management activities, coordination and patient engagement. Develop programs to implement telehealth, eReferral/eConsult to enhance access to behavioral health services.
Applicable	**1.1.14** Demonstrate patient engagement in the design and implementation of the project.

Check, if applicable	Description of Core Components
Applicable	**1.1.15** Increase 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	**1.1.16** Ensure integration is efficient and providing value to patients by implementing a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

☒ 1.2 Ambulatory Care Redesign: Primary Care (required for DPHs)

Rationale for Project: VCHCA leaders recognize the need for Ambulatory Care redesign to overcome the gaps in the current model. Identifying health disparities (see Section 2.1) serves as the foundation for the development of initiatives designed to improve care coordination, quality of care, and clinical outcomes. VCHCA's goal is to train professionals to support care coordination and the integration of multidisciplinary services. Current workforce training gaps include the lack of a structured PCMH model used across the system and the lack of infrastructure to implement PCMH, such as staffing and technology. The project is necessary to implement evidence-based PCMH population health management strategies to drive system-wide improvements.

Planned Implementation Approach: The VCHCA's PCMH Committee will utilize the IHI's PDSA methodology[33] to transform the primary care delivery system and drive implementation of the NCQA PCMH model,[34] with the goal of NCQA recognition for VCHCA clinical practices. This project will be achieved by:

1. Developing effective PCMH curricula, a CME lecture series, written training scripts, and training materials
2. Training primary care teams, comprised of PCPs, LIPs, care managers, RNs, LVNs, MAs, CHWs, patient advisory committee members, and patients
3. Transforming the practice of VCHCA clinics toward a PCMH model of care
4. Achieving an NCQA PCMH designation in at least 70% of the primary care clinics by the project's end

The training will focus on:

1. An evidence-based PCMH curriculum
2. Training multidisciplinary teams
3. Coordinated care through PCP-led, patient-focused practices
4. Whole-person orientation through comprehensive care
5. Culturally and linguistically appropriate services

6. Quality improvement and safety practices
7. Use of HIT
8. Health system integration

Prevention-focused initiatives will result in system-wide screenings based on risk, interventions, and chronic disease management goals.

Target Population: The target population will include all primary care clinic patients served by an integrated care team trained in the PCMH model. The PCMH model will initially be launched at selected clinics based on the quality improvement process and the PCMH Committee's determination of clinical staff readiness and performance improvement methodologies that are in place. The model will then be spread to remaining clinics throughout the system.

Vision for Care Delivery: The implementation strategies will result in improved coordination of care and improved access to services, with an emphasis on self-management and education to improve health status and quality of life. The VCHCA vision for PCMH transformation is expected to result in the following:

1. Decreases in the cost of care, such as per member per month costs, and increases in return on investment
2. Reductions in the use of unnecessary or avoidable services, such as ED or urgent care visits, and inpatient admissions/readmissions
3. Improvements in population health indicators and increases in preventive services, such as better controlled HbA1c, blood pressure, and statin use and increases in screening and immunization rates
4. Improvements in access to care, such as improved overall access to primary care
5. Improvements in patient satisfaction, such as overall satisfaction, recommending the practice to family and friends, and satisfaction with provider communications

Providing PCMH training across VCHCA will unify all care providers around the model's evidence-based central concepts that have produced dramatic improvements in the quality of care in other health care systems.[35]

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

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

Check, if applicable	Description of Core Components
Applicable	**1.2.3** Hiring and training of frontline workforce (e.g., medical assistants, community health workers, promotoras, health navigators or other non-licensed members of the care team) to be responsible for coordination of non-clinical services and elements of the care plan.
Applicable	**1.2.4** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population/panel management activities, care coordination, patient engagement, and operational and strategic decisions including a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. • Implementation of EHR technology that meets meaningful use (MU) standards.
Applicable	**1.2.5** Ongoing identification of all patients for population management (including assigned managed care lives): • Manage panel size, assignments, and continuity to internal targets. • Develop interventions for targeted patients by condition, risk, and self-management status. • Perform preventive care services including mental health and substance misuse screenings and brief interventions (e.g., PHQ-9, SBIRT).
Applicable	**1.2.6** Enable prompt access to care by: • Implementing open or advanced access scheduling. • Creating alternatives to face-to-face provider/patient visits. Assigning frontline workers to assist with care navigation and non-clinical elements of the care plan.
Applicable	**1.2.7** Coordinate care across settings: • Identification of care coordinators at each primary care site who are responsible for coordinating care within the PCMH as well as with other facilities (e.g., other care coordinators or PCMH/DPH/DMPH high risk care managers): o Establish onsite care/case managers to work with high risk patients and their care teams, or develop processes for local care coordinators to work with a central complex care management program for these patients Implement processes for timely bi-directional communication and referral to specialty care (including mental health and substance use disorder services), acute care, social services and community-based services.
Applicable	**1.2.8** Demonstrate evidence-based preventive and chronic disease management.

Check, if applicable	Description of Core Components
Applicable	**1.2.9** Improve staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the team-based care model to ensure effective and efficient provision of services (e.g., group visits, medication reconciliation, motivational interviewing, cognitive behavioral therapy and Medication-Assistance Treatment (MAT)).
Applicable	**1.2.10** Engage patients using care plans, and self-management education, and through involvement in the design and implementation of this project.
Applicable	**1.2.11** Improve the accuracy and completeness of race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI) data, and use that data to identify and reduce disparities in one or more Primary Care Redesign project metrics by: • Adding granular REAL and SO/GI data to demographic data collection processes and training front-line/registration staff to gather complete and accurate REAL/SO/GI data. • Developing capacity to track and report REAL/SO/GI data, and data field completeness. • Implementing and/or refining processes for ongoing validation of REAL/SO/GI data. • Developing capacity to stratify performance metrics by REAL/SO/GI data and use stratified performance data to identify disparities for targeted interventions. • Developing capacity to plan and implement disparity reduction interventions with input from patients and community stakeholders. • Developing dashboards to share stratified performance measures with front-line staff, providers, and senior leadership.
Applicable	**1.2.12** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

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

Rationale for Project: Although VCHCA has access to of a wide array of specialties, a number of gaps exist including: insufficient specialists for the service demand, inconsistent care instructions provided to PCPs from different specialists, and overuse of specialists when other trained health care professionals can provide many of the treatment plan services. PCMH initiatives can improve these conditions, but

specific project components are needed to fully rectify the issues with specialty care that limit the provision of timely, quality services and improvements in patient satisfaction.

Planned Implementation Approach: Involving VCHCA specialists in PCMH transformation, disease registries, and care management tools will ensure that PCMH core methods improve specialty care integration with primary care health management and care coordination. Additional elements from evidence-based models of specialty care referral efficiency will be implemented, including the Innovative CME model and Interactive Referral Guidelines model.[36]

The referral loop will be closed by ensuring that a specialist report is provided to the referring PCP once the specialist sees the patient. Co-management plans involving both the PCP and specialist will be created for all applicable patients. Evidence-based clinical practice guidelines will be used system-wide for diseases that are prevalent among the served population. Specialists will train primary care teams through conferences or CMEs/CEUs about providing condition-specific treatments in the primary care setting.

Improvements in patient access will be achieved by increasing communications through non-face-to-face means (i.e., phone calls, emails, digi-health, telemedicine), and by training primary care teams to provide applicable condition-specific treatments. The use of telemedicine will increase capacity by building infrastructure and PCP/specialist training. HIT improvements will be used to improve communication and collaboration between PCPs and specialists. A robust e-referral system will ensure proper communication and continuum of care between PCPs and specialists and timely treatment of urgent cases.

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

Target Population: The target population will be all patients referred to specialists based on condition. Condition-specific practice management guideline rollouts will be prioritized based on rapid cycle improvement processes.

Vision for Care Delivery: The overall vision for care delivery will be coordinated care across all departments and specialties, whereby PCPs, specialists, and other health care professionals work together toward whole person-focused care. Patient "ownership" defines the system, and PCMHs coordinate with other professionals to ensure optimal patient outcomes.

Based on model evidence, referral-to-appointment turn-around rates will be reduced significantly through these interventions, enabling specialists to evaluate and treat patients before their conditions become more acute. Proper preliminary work-ups will be provided by PCPs, reducing the need for multiple specialist appointments. Specialty care costs will be reduced through implementation of condition practice management guidelines, non-face-to-face communications, and the use of telemedicine when

appropriate.

Practice management guidelines and PCP condition-specific training will improve timely patient treatments in the primary care setting, thereby improving patient outcomes and satisfaction while reducing the over-demand on the specialty care system. HIT information about appointment delays after system optimization will inform administration of the need to hire additional staff for a particular specialty or determine if there are other quality improvements that can improve turn-around rates. The proposed project will decrease avoidable specialty and other acute care overutilization, improve patient access to specialists, increase specialty staff communication/collaboration with the patients and PCP, and improve patient satisfaction and outcomes.

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

Check, if applicable	Description of Core Components
Applicable	**1.3.1** Develop a specialty care program that is broadly applied to the entire target population.
Applicable	**1.3.2** Conduct a gap analysis to assess need for specialty care including mental health and SUD services (analysis to include factors impacting ability to access specialty care), and the current and ideal state capacity to meet that need. Benchmark to other CA Public Health Care systems.
Applicable	**1.3.3** For ideal state analysis, include potential impact of increased primary care capacity to manage higher acuity conditions either independently, or in collaboration with, specialty care, so as to reduce the need for in-person specialty care encounters (e.g., insulin titration, IBS management, joint injections, cognitive behavioral therapy (CBT) or MAT).
Applicable	**1.3.4** Engage primary care providers and local public health departments in development and implementation of specialty care model.
Applicable	**1.3.5** Implement processes for primary care/specialty care co-management of patient care.
Applicable	**1.3.6** Establish processes to enable timely follow up for specialty expertise requests.
Applicable	**1.3.7** Develop closed loop processes to ensure all requests are addressed and if in person visits are performed, that the outcome is communicated back to the PCP.

Check, if applicable	Description of Core Components
Applicable	**1.3.8** Ensure that clinical teams engage in team- and evidence-based care.
Applicable	**1.3.9** Increase staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the care model.
Applicable	**1.3.10** Develop and implement standardized workflows for diversified care delivery strategies (e.g., shared medical visits, ancillary led services, population management, telemedicine services) to expand access and improve cost efficiency.
Applicable	**1.3.11** Adopt and follow treatment protocols mutually agreed upon across the delivery system.
Applicable	**1.3.12** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population management activities and care coordination/transitions of care. Ensure that timely, relevant, and actionable data are used to support patient engagement, PCP collaboration, and drive clinical, operational and strategic decisions including continuous quality improvement (QI) activities.
Applicable	**1.3.13** Implement EHR technology that meets MU standards.
Applicable	**1.3.14** Patients have care plans and are engaged in their care. Patients with chronic disease (including MH/SUD conditions) managed by specialty care have documented patient-driven, self-management goals reviewed at each visit.
Applicable	**1.3.15** Improve medication adherence.
Applicable	**1.3.16** Implement population management strategies for patients in need of preventive services, with chronic conditions, or with recurring long term surveillance needs.
Applicable	**1.3.17** Implement or expand use of telehealth based on DPH/DMPH capacity to address patient and PCP barriers to accessing specialty expertise. Implement a telehealth platform with communication modalities that connect between specialty care and primary care (e.g., eConsult/eReferral).

Check, if applicable	Description of Core Components
Applicable	**1.3.18** Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**1.3.19** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.
Applicable	**1.3.20** Test use of novel performance metrics for redesigned specialty care models.

☒ 1.5 – Million Hearts Initiative

Rationale for Project: Although VCHCA primary care services have a strong prevention focus, early identification is a key factor in achieving Million Hearts Initiative goals. Patients often present to PCPs after their chronic conditions worsen. The VCHCA Public Health Department has successful programs that can facilitate Million Hearts goals, including:

[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.*

1. Tobacco Education and Prevention
2. Chronic Disease Prevention and Early Detection
3. Preventive Care for Adults

However, the department's chronic disease prevention and VCHCA treatment services are not coordinated, so there is currently no unified way of connecting patients with appropriate services outside of each contained department.

Planned Implementation Approach: VCHCA will integrate cardiovascular chronic disease prevention through its Chronic Disease Prevention Taskforce that will be charged with designing and implementing quality improvements to coordinate care for cardiovascular conditions. Improvements in coordinated care between the PCPs, cardiologists, and other providers will be accomplished through initiatives in Project 1.3. Coordination protocols will facilitate standardizing chronic disease clinical management so that cross departmental referrals effectively utilize existing resources. Ongoing risk factor assessment and care, and resource referral follow-up, will be facilitated through primary care practices. HIT improvements will assist in data mining of metrics/indicators. Evidence-based practices will be utilized:

1. *Tobacco Cessation:* PCP use of oral medications when indicated; nicotine replacement therapy; in-person smoking cessation classes/counseling; and access to tobacco cessation services.
2. *Hypertension Control:* PCP use of oral medications; access to DASH diet information and dietitians; health education in stress-reduction strategies, salt intake, reduction of alcohol consumption, tobacco cessation, and weight loss strategies; access to community exercise programs; and follow-up screenings provided on a regular basis.
3. *Ischemic Vascular Disease Control:* Treatment by aspirin use or anti-thrombotic pharmaceuticals will be prescribed according to U.S. Preventive Services Task Force Guidelines,[37] with monitoring of adverse effects and follow-up.

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

Target Population: The target population will be patients identified through hospital, specialist, PCP assessment or community outreach as being at risk for cardiovascular disease, as indicated by age, diabetes, total cholesterol levels, HDL, LDL and triglyceride levels, blood pressure, and tobacco use.

Vision for Care Delivery: When the VCHCA Chronic Disease Prevention Task Force completely implements the integration process, all providers across VCHCA (hospitalists, specialists, primary care professionals, Public Health and Behavioral Health professionals) will have clear decision support guidelines on what to do when staff identify someone at risk for cardiovascular disease. System-wide announcements, conferences, and staff meetings will review protocols, answer questions, and facilitate programmatic quality improvements as indicated. Chronic disease prevention resource lists, contact information, referral protocols, and clinical practice management guidelines will be available to all health professionals who serve the target population.

Improvements in HIT will enable administrative staff to identify practices that are not meeting organizational/Million Hearts goals to ensure they are utilizing system-wide protocols properly, and to closely track progress toward identified metrics. EHR clinical decision support will assist providers in adhering to protocols. The development of a consolidated list of VCHCA and community patient support services will be accessible through a VCHCA chronic disease prevention and management website. Project implementation will result in earlier treatment for risk factors, management of chronic conditions within identified ranges, and reduced incidence of smoking among the population, which in turn will result in improved patient outcomes.

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.
Applicable	**1.5.8** Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.

Please complete the summary chart:

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

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

☒ 2.1 – Improved Perinatal Care (required for DPHs)

Rationale for Project: VCHCA has a robust Maternal Newborn program that has made great strides in advancing perinatal health. The challenges faced in prenatal care in Ventura County include higher than average rates of obesity, pre-existing hypertension, and pregnancy-related diabetes. At least 30% of pregnant women covered under Medi-Cal have inadequate prenatal care.[38] Repeat cesarean delivery rates have ballooned from 2000 to 2010, increasing from 11.0% to 15.9%, primarily stemming from local hospitals and physicians avoiding the perceived risk of increased morbidity and fear of litigation despite evidence to the contrary.[39]

Planned Implementation Approach: VCHCA is already a member of the California Maternal Quality Care Collaborative (CMQCC)[40] and Patient Safety First Initiative.[41] VCHCA physicians and staff participate in CMQCC learning collaboratives surrounding topics, such as post-partum hemorrhage, pregnancy-induced hypertension, and fetal monitoring. Ongoing education is provided to all VCHCA physicians with obstetrical privileges to ensure consistency with guideline adherence. The implementation approach is to expand and improve efforts surrounding reducing the rate of cesarean sections, improve outcomes for women at high-risk for post-partum complications, improve management of women with pre-eclampsia and maternal hypertension, and improve care transitions for women with gestational diabetes. VCMC will launch the first comprehensive trial of labor after cesarean (TOLAC) program in the county Summer 2016 to reduce repeat cesarean birth rates among low-risk mothers. The PRIME project will facilitate improvements in outcomes surrounding the TOLAC program and the overall VCMC perinatal care program by the following activities: 1) TOLAC clinical guidelines will be reviewed and revised as indicated by best practices to optimize outcomes and resources. 2) VCMC will track PRIME and TOLAC program metrics, including auditing appropriate stratification of TOLAC candidates and the rates of failed and successful TOLACs. This data will be used to

measure program performance against benchmarks and to inform PDSA methodologies. 3) PRIME care managers will link and coordinate care for mothers identified as high-risk for post-partum complications, including diabetes, depression, and hypertension. 4) VCHCA will initiate additional components of the CMQCC toolkit around maternal hemorrhage as determined through PDSA methodologies, including hemorrhage simulators using mannequins. 5) CMQCC evidence-based tool kits and provider education will be implemented to improve management and outcomes surrounding pre-eclampsia and maternal hypertension, such as the initiation of physician-led phone drills when managing patients in active labor with evidence of mild to severe pre-eclampsia. 6) Pre-eclampsia and maternal hypertension protocols will be reviewed around evaluation, management, and monitoring for toxicity or complications. 7) Care coordination for women who are identified with gestational diabetes will be launched by improving communication protocols with VCHCA system and external providers. VCMC and Santa Paula Hospital are currently designated Baby Friendly Hospitals and will continue to maintain this accreditation to foster an environment that promotes early and sustained breastfeeding.[42]

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

Target Population: The target population will be:

1. Pregnant women who have undergone previous cesarean sections that are candidates for a TOLAC program
2. Laboring women who are at risk for significant post-partum hemorrhage
3. Mothers who face barriers or uncertainty about the benefits of breastfeeding

Vision for Care Delivery: The vision for care delivery is to minimize post-partum hemorrhage and complications, and improve care and outcomes for women with high-risk conditions. Reducing both the primary and repeat cesarean delivery rates will have a tremendous impact on the overall health of women. A cesarean delivery, despite overall efficacy, carries a higher risk of bleeding, transfusions, and infections, as well as a longer recover time. Among pregnant women who are considered good candidates for a TOLAC, the program will transform the mindset of pregnant women and physicians to ensure assessment for the option of vaginal delivery.

Efforts to minimize the impact of post-partum hemorrhage will center upon the proper identification of women most at risk for significant bleeding. Policies and training will be put in place to immediately respond when the situation arises. Best practices will include mock drills, thorough transfusion protocols, and coordination between nursing and physicians to expedite guideline-based decisions. Women with gestational diabetes will have appropriate outpatient evaluation, testing, and follow-up in the post-partum setting as coordinated through new communication protocols and methods.

As part of the Baby Friendly Hospital Initiative Guidelines, physicians and staff will

continue to be equipped and educated about how to best counsel their patients about the benefits of breastfeeding. VCMC will evaluate policies to ensure that an environment that supports and promotes breastfeeding is encouraged, including extending the care continuum beyond the hospital and into the immediate post-partum period when the risk of discontinuation is highest.

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

Check, if applicable	Description of Core Components
Applicable	**2.1.1** DPHs/DMPHs engagement in best practice learning collaborative to decrease maternal morbidity and mortality related to obstetrical hemorrhage (CMQCC/PSF/HQI combined effort).
Applicable	**2.1.2** Achieve baby-friendly hospital designation through supporting exclusive breastfeeding prenatally, after delivery, and for 6 months after delivery and using lactation consultants after delivery.
Applicable	**2.1.3** Encourage best practice and facilitate provider education to improve cesarean section rates, and decrease inequities among cesarean section rates. Participate, as appropriate, in statewide QI initiatives for first-birth low-risk cesarean births.
Applicable	**2.1.4** Coordinate care for women in the post-partum period with co-morbid conditions including diabetes and hypertension.

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

Rationale for Project: The lack of comprehensive integrated care transition processes that address the specific needs of high-risk patients from the inpatient/ED to ambulatory care settings creates risks to patient safety. Readmission rates have been high in recent years because of multiple population health and care management factors. To address this, VCHCA developed the Transitions Clinic in February 2015 through DSRIP, which serves as a critical transition for patients who have been discharged but need follow-up care before their next primary care visit in order to avoid readmission. All cause 30-day readmission rates have improved, yet remained high (7.9% in 2015) for patients not treated through this program (see Table 5).

Planned Implementation Approach: Utilizing the Joint Commission's Transitions of Care Initiative, which was based on common elements from multiple evidence-based models, VCHCA will transform hospital care transitions for high-risk patients. All patients will be assessed for the need for transition services. Patients with identified risk factors will be visited by the Care Transitions team prior to transition of care. Implementation will include:

1. Improvements in multidisciplinary communication, collaboration, and coordination
2. Patient/caregiver education
3. Clinician involvement
4. Comprehensive planning and risk assessment throughout the hospital stay
5. Standardized transition plans, procedures, and forms
6. Medication reconciliation
7. Training of hospital and primary care/post-acute setting staff
8. Timely follow-up, support, and coordination after the patient leaves the hospital setting
9. Analysis of causal factors if a patient is readmitted
10. Evaluation and quality improvement of care measures, tools, and procedures

Standardized SBAR procedures with clinicians will determine the transition of care treatment plan, which will be developed with the receiving clinician. High-risk patients also often have complex multiple social, emotional, physical, nutritional, pharmaceutical, and care needs. Staff will be trained in warm hand-offs utilizing the Joint Commission's Communication Tool.

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 will be all hospital patients who are transitioned to post-acute care (home or facility), as all patients will be assessed for the level of care needed after the transition. High-risk patients identified through assessment will have an appropriate transition plan developed by their coordinated, multidisciplinary treatment team (i.e., Care Transitions team, PCP, transitional facility, specialist, and community-based resources).

Vision for Care Delivery: This care transitions project will enable VCHCA to address high readmission and ED visit rates for high-risk patients through standardized, system-wide, evidence-based processes. Ensuring that patients receive needed aftercare subsequent to discharge, risks to patient safety are identified and mitigated. Ensuring that patients are adhering to treatment plans will result in improved outcomes. Specifically, studies of transitional care models using elements proposed in this project have shown that there are reductions in re-hospitalizations or death, reductions in the average number of days hospitalized during the year, savings in per patient health care expenditures, and significant patient satisfaction improvements.[43] Staff training about warm handoff methods will further improve communications throughout VCHCA. Developing a centralized list and improving collaboration with system-wide providers and community resources will not only improve transition planning, but will also facilitate communication throughout the agency. All discharged patients will benefit from the project's improved assessment capabilities and collaboration with PCMHs. Specific education and instructions to patients/caregivers and a reconciled

medications list communicated to the transitional treatment team will improve patients' self-management and satisfaction while reducing the risk of readmission.

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.

Check, if applicable	Description of Core Components
Applicable	**2.2.5** Inpatient and outpatient teams will collaboratively develop standardized transition workflows: • Develop mechanisms to support patients in establishing primary care for those without prior primary care affiliation. Develop process for warm hand-off from hospital to outpatient provider, including assignment of responsibility for follow-up of labs or studies still pending at the time of discharge.
Applicable	**2.2.6** Develop standardized workflows for post-discharge (outpatient) care: • Deliver timely access to primary and/or specialty care following a hospitalization. • Standardize post-hospital visits and include outpatient medication reconciliation.
Applicable	**2.2.7** Support patients and family caregivers in becoming more comfortable, competent and confident in self-management skills required after an acute hospitalization by providing: • Engagement of patients in the care planning process. • Pre-discharge patient and caregiver education and coaching. • 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.

Check, if applicable	Description of Core Components
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)

Rationale for Project: Complex care management is needed to reduce the cost of care while improving patient outcomes. Patients who utilize the hospital and ED most significantly impact the cost of care. For example, the average Ventura County patient with COPD visits the ED or is admitted to the hospital an average of once per 562 days. The greatest resource-utilizing patients (top 5%) were responsible for more than 20% of COPD hospital visits, averaging two visits a year.

Planned Implementation Approach: VCHCA will bring together the Complex Care Management Taskforce to develop effective strategies concerning the agency's complex care management program. The program will focus on developing specially-trained, multidisciplinary teams that coordinate closely with primary care teams to meet the needs of patients with multiple chronic conditions or advanced illness, including those with social or economic barriers. This program will:

1. Identify high-risk or high-utilization patients based on identified parameters
2. Perform comprehensive health, social, and environmental assessments as indicated
3. Identify a complex care trained multidisciplinary team based on assessment results
4. Ensure medication reconciliation is conducted
5. Work closely with patients and caregivers to mitigate factors that affect over-utilization of care services.

The taskforce will:

1. Evaluate the status of implementation of care coordination models
2. Tie complex care development with care transitions
3. Identify multidisciplinary teams that need to be included
4. Determine agency and community resources and workforce needs
5. Determine the initial clinical and utilization parameters used to determine inclusion criteria
6. Develop databases for effective care management of high utilizers
7. Upgrade the EHR to meet the demands of care management
8. Develop a claims-reporting system from which complex care patients can be identified
9. Develop an implementation plan that will match service level to patient needs
10. Establish implementation strategies and timelines.

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

Target Population: The taskforce will establish the target population during the project planning and development phase. The target population will be identified based on the overall cost to the system as determined by utilization criteria, such as diagnosis severity, number of hospitalizations, and the risk of complications that require more resources to manage.

Vision for Care Delivery: The goals are to achieve better care coordination and alignment for high-risk, high-cost populations; maintain or improve patients' functional status; increase patients' capacity to self-manage their condition; eliminate unnecessary clinical testing; and reduce the need for acute care services. This project will address patients' physical conditions and the co-existing behavioral health and socioeconomic challenges that increase their likelihood of hospitalization. Adopting a patient-centered care management approach will reduce unnecessary hospitalizations and ED visits. The complex care project model will use qualitative and quantitative methods to identify high-utilizing patients. It will then prioritize care coordination, build trust between patients and PCPs, form care teams that meet the patient's needs, and use technology to enhance care management activities. Where appropriate, telehealth will contribute to effective care management of selected patients and provide additional cost-effective options to increase patient access. Primary care–integrated complex care management will extend beyond medical issues to address how patients' psychosocial circumstances affect their ability to follow treatment recommendations and achieve a healthy lifestyle. This project will be developed synergistically with other defined PRIME quality improvement projects, including Project 2.2.

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.
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.

☒ 2.4 – Integrated Health Home for Foster Children

Rationale for Project: A number of initiatives have demonstrated that foster care children need a more integrated approach to care.[44,45,46] Additionally, the DHCS Whole Person Care pilot will provide integrated care coordination for high utilizers of multiple systems, such as foster children.[47] Ventura County foster children have many complex health needs that require ongoing care coordination across settings that are not currently in place to both care for the "whole child" as well as address the multiple reform and quality improvement initiatives.

Planned Implementation Approach: This project, which will tie into Projects 1.1 and 1.2, will more closely integrate physical, behavioral, and specialty care and provide care coordination to ensure improvements in health outcomes. A care management program based in primary care will ensure that foster children:

1. Have a consolidated treatment plan
2. Access needed services
3. Manage their medications
4. Receive integrated behavioral health services
5. Connect with all needed social and legal supports outside of VCHCA.

Ventura County Human Services Agency (VCHSA) social workers will be part of the integrated multidisciplinary care team to ensure that all foster children are assessed for community-based service needs. Through connections/referrals by VCPH department PHNs, VCHCA annually assesses approximately 580 foster children for health care and oral health needs after placement. Foster children will then be flagged in the EHR, and a care management team will contact the foster parent to arrange a full assessment. The multidisciplinary care team will meet regularly to collaborate, using evidence-based standards of care for identified needs and case reviews to determine changes. Regularly scheduled well-child visits and developmental and behavioral health screenings will ensure that treatment plans are current to needs.

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

Target Population: The target population is all children and youth under the age of 18 placed in out-of-home foster care through the Ventura County Human Services Agency.

Vision for Care Delivery: The integrated health home for foster children project will provide:

1. Comprehensive care management
2. Care coordination across health/behavioral health care, community, and school settings
3. Health promotion

4. Foster child and family support
5. Connections with community and social support services.

The multidisciplinary care team will include VCPH PHNs, probation officers, VCHSA social workers, PCPs, behavioral health professionals, care managers, and other community resources indicated by the treatment plan. Care coordination through an integrated health home will ensure that foster children are not provided psychotropic medication without accompanying mental health treatment or that these medications are not prescribed to very young children. Improvements in analytics, monitoring, and reporting functions in the EHR will enable the multidisciplinary care team and VCHCA leadership to quickly identify project deficiencies and implement rapid cycle quality improvements. Evidence-based guidelines that address chronic and behavioral health conditions will ensure that standardized care is provided. Access to the EHR, regular care team meetings, and the Ventura County Foster Health Link[48] (a website and mobile application that provides child-specific health information and school-based special education plans) will facilitate communication among the care team. The project is designed to improve the foster child's access to screenings/assessments and identified needs.

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

Check, if applicable	Description of Core Components
Applicable	**2.4.1** Healthcare systems receive support in the ongoing management and treatment of foster children: Demonstrate engagement of patients and families in the design and implementation of this project.
Applicable	**2.4.2** Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration).
Applicable	**2.4.3** Multi-therapeutic care team will: • Identify patient risk factors using a combination of qualitative and quantitative information. • Complete a patient needs assessment using a standardized questionnaire. • Collaborate on evidence-based standards of care including medication management, care coordination and care engagement process. • Implement multi-disciplinary case conferences/consults on patients with complex needs. • Ensure the development of a single Treatment Plan that includes the patient's behavioral health issues, medical issues, substance abuse and social needs: o Use of individual and group peer support. • Develop processes for maintaining care coordination and "system continuity" for foster youth who have one or more changes in their foster home.

Check, if applicable	Description of Core Components
	• Ensure that the Treatment Plan is maintained in a single shared EHR/clinical record that is accessible across the treatment team to ensure coordination of care planning. • Assess and provide care for all routine pediatric issues with a specific focus on: o Mental health/toxic stress o Obesity o Chronic disease management o Medication/care plan adherence which are vulnerable when kids transition care givers frequently o Substance abuse issues o Developmental assessment, identification and treatment
Applicable	**2.4.4** Implement technology-enabled data systems to support pre-visit planning, point-of-care delivery, population/panel management activities and care coordination. Timely, relevant and actionable data is used to support patient engagement, and drive clinical, operational and strategic decisions including continuous QI activities.
Applicable	**2.4.5** Provide linkages to needed services that at a minimum includes child welfare agency, mental health, substance abuse and public health nursing as well as any other social services that are necessary to meet patient needs in the community.
Applicable	**2.4.6** Develop liaisons/linkage with school systems.
Applicable	**2.4.7** Provide timely access to eligibility and enrollment services as part of the health home services.
Applicable	**2.4.8** Evidence-based practice guidelines will be implemented to address risk factor reduction (e.g., immunization, smoking cessation, behavioral health screening) as well as to ensure appropriate management of chronic diseases (e.g., asthma, diabetes). Assessment of social service needs will be integral to these activities. Educational materials will be utilized that are consistent with cultural and linguistic needs of the population.
Applicable	**2.4.9** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement, that includes patients, front line staff, and senior leadership.

Please complete the summary chart:

	For DPHs	For DMPHs

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

Section 4.3 – Domain 3: Resource Utilization Efficiency

☒ 3.4 – Resource Stewardship: Blood Products

Rationale: The VCMC Blood Usage Committee has determined through transfusion audits that some of the metrics within the blood products management program fall outside of established guidelines. For example, in a recent audit of all red blood cells transfused, 21% did not have documentation supporting the appropriateness of the transfusion according to AABB guidelines. Moreover, there is no consistent method of recording physician rationale for these outlier events. Transfusion events that fall outside of standards are not only potentially an inappropriate use of resources, but could create a higher level of adverse events for the patients and system, including transfusion reactions and transmission of blood-borne pathogens.

Planned Implementation Approach: The Patient Blood Management (PBM) program will implement AABB guidelines system wide. Physicians will be trained on these guidelines. Clinical decision support will be integrated into the EHR to enable physicians to see guideline components during the ordering process. An order in conflict with the guidelines will prompt an alert asking for rationale behind the decision. Computerized Physician Order Entry (CPOE) reports will enable physicians and the Blood Usage Committee to determine what actual criteria are being used to design rapid cycle improvement projects. Dashboards will enable the Blood Usage Committee and hospital Performance Improvement Coordinating Council to compare established guidelines to results over time and to set priorities for system improvement. Metrics will be incorporated into the blood management program and EHR, including data related to preoperative anemia and preoperative ordering practices, transfusion events in the hospital, and physician-specific audits of pre-transfusion hemoglobin. Analytic processes will focus on the blood management program's utilization improvements due to guideline implementation, education, and documentation. Outcomes will be measured, including transfusion appropriateness, costs, and adverse events related to transfusion decisions and methodology.

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

Target Population: The target population is all VCHCA patients at risk of a transfusion event.

Vision for Care Delivery: The PBM program will more efficiently determine and standardize which blood product each patient needs, when they need the blood product, and the correct dose required to optimize patient outcomes with reduced adverse events. Standardized guidelines will inform which patients get screened preoperatively and/or are provided risk assessments to ensure that patients are in the best possible health prior to surgery. Implementation of guidelines will augment and integrate best practices of the VCHCA PBM program already in place, such as:

1. Utilization of intraoperative blood salvage
2. Minimizing perioperative allogeneic blood transfusions
3. Management and use of blood factors
4. Use of the Thromboelastography (TEG) and other point-of-care technologies to adapt transfusion strategies to specific patient needs.

Improved analytics will provide the ability for rapid identification of deviation from guidelines and drive quality improvement initiatives. The Blood Usage Committee will have improved monitoring and report capabilities to effectively review blood utilization and implement performance improvement strategies. Patient engagement will be optimized by educating patients about the transfusion decision-making process, expanding and standardizing the informed consent process and including options to transfusion, such as the right to delay elective procedures or provide autologous transfusion prior to procedures. The project is designed to optimize blood product resource utilization, resulting in lower cost of care and improved patient outcomes.

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.

Check, if applicable	Description of Core Components
Applicable	**3.4.8** Participate in the testing of novel metrics for PBM programs.

Please complete the summary chart:

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

Section 5: Project Metrics and Reporting Requirements

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

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

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

processes and infrastructure to support MCP achievement of quality improvement efforts when aligned with PRIME projects.

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

Section 6: Data Integrity

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

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

Section 7: Learning Collaborative Participation

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

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

Section 8: Program Incentive Payment Amount

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

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

- DY 11 $ 94,340,400
- DY 12 $ 94,340,400
- DY 13 $ 94,340,400
- DY 14 $ 84,906,360
- DY 15 $ 72,170,406

Total 5-year prime plan incentive amount: $ 440,097,966

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 Measure

NOT APPLICABLE – Applicant is a DPH.

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

Appendix – Supplemental Tables and Endnotes

Table 1: Ventura County Death Rate per 100,000 Residents, Selected Cause of Death		
Cause of Death	**Ventura County**	**California**
Female Breast Cancer	21.3	20.7
Unintentional Injuries	31.0	27.9
Suicide	11.6	10.2
Drug-Induced	13.9	11.1
Latino Infant Mortality (per 1,000 live births)	4.9	4.7

Source: California Department of Public Health, Center for Health Statistics and Informatics, County Health Status Profiles 2015

Attachment 1: VCHCA Organizational Structure

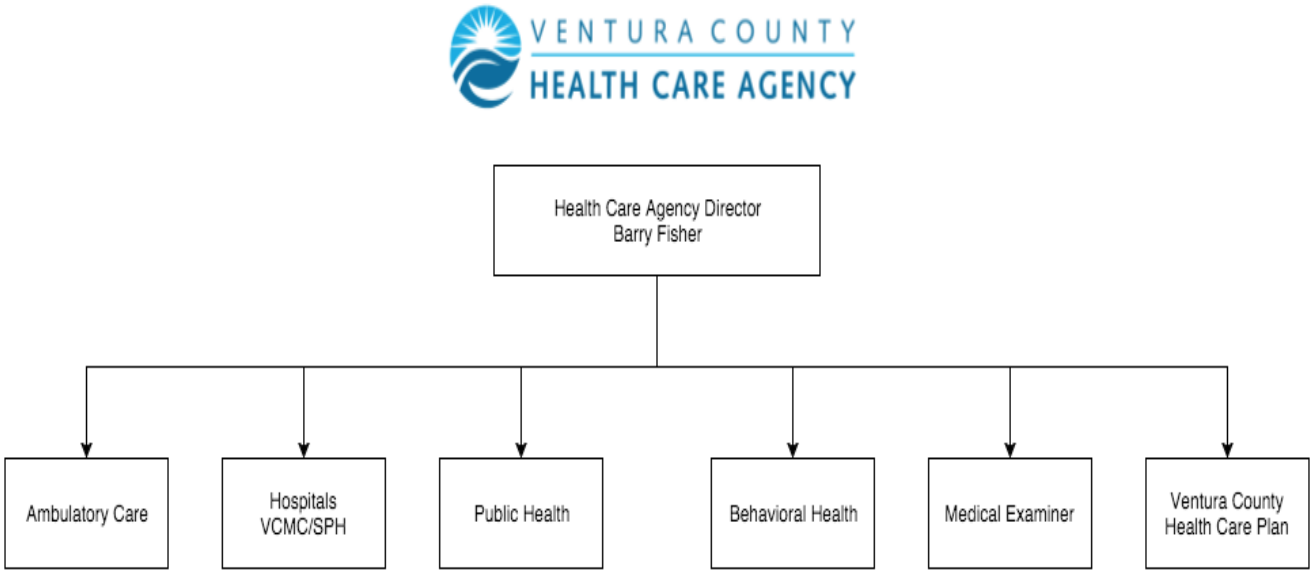

Table 2: VCHCA Clinics (41 total)		
FQHC (19)	**Other Primary and/or Specialty (14)**	**Urgent Care (8)**
Conejo Valley Family Medical Group	Academic Family Medicine Center (AFMC)	AFMC UC
Fillmore Family Medical Group	Adult Hematology-Oncology	Conejo UC
John K. Flynn Community Clinic	Anacapa Surgical Associates	Fillmore UC
Las Islas Family Medical Group North	Neuroscience Center of Ventura County West	Las Islas UC
Las Islas Family Medical Group	Cardiology Clinic	Magnolia UC
Las Islas Mobile Clinic	Immunology Clinic	Mariposa UC
Las Posas Family Medical Group	Medicine Specialty Center West	Sierra Vista UC
Magnolia West	Orthopedic Clinic	West Ventura UC
Magnolia Family Medical Center (MSC-East)	Plastics, Reconstructive and Hand Clinic	
Mandalay Bay Women & Children's	Neuroscience Center of Ventura County (ASA)	
Moorpark Family Medical Clinic	Pediatric Hematology-Oncology	
Pediatric Diagnostic Center	Camarosa Springs Med. Group	
Piru Family Medical Center	Citrus Grove Medical Clinic	
Santa Paula Hospital Clinic	Mountain View Family Med. Clinic	
Santa Paula Medical Clinic		
Santa Paula West		
Sierra Vista Family Medical Clinic		
Ventura County Healthcare for the Homeless Program		
West Ventura Medical Clinic		

Table 3: VCHCA Specialties			
Departments (7)	**Specialties (60)**		
Family Medicine (2)	Emergency Medicine	Family Medicine	
Medicine (23)	Allergy/ Immunology	Cardiology	Cardiology, Interventional
	Cardiovascular Disease	Critical Care Medicine	Dermatology
	Electrophysiology	Endocrinology	Gastroenterology
	Geriatric Medicine	Hematology/Oncology	HIV Medicine
	Internal Medicine	Nephrology	Neurology
	Nuclear Medicine	Pathology	Physical Med. & Rehab
	Pulmonary Medicine	Radiation Oncology	Radiology, Diagnostic
	Radiology, Interventional	Rheumatology	
Obstetrics & Gynecology (2)	Gynecologic Oncology	Obstetrics & Gynecology	
Pediatrics (14)	Neonatology	Neonatal & Perinatal Medicine	Pediatric Hem./Oncology
	Pediatric Cardiology	Pediatric Dermatology	Pediatric Endocrinology
	Pediatric Gastroenterology	Pediatric Nephrology	Pediatric Neurology
	Pediatric Ophthalmology	Pediatric Rheumatology	Pediatric Urology
	Pediatric Critical Care	Pediatrics	
Psychiatry (2)	Psychiatry	Child & Adolescent Psychiatry	
Psychology (1)	Psychology		
Surgery (16)	Anesthesiology	Bariatric Surgery	Cardiovascular Surgery
	General Surgery	Neurosurgery	Ophthalmology
	Oral & Maxillofacial Surgery	Orthopedic Surgery	Otolaryngology
	Pediatric Surgery	Plastic Surgery	Podiatry
	Surgical Oncology	Thoracic Surgery	Urology
	Vascular Surgery		

Table 4: VCHCA Alignment Between Goals, Aims, and Projects*		
Goals	**Aims**	**Projects**
Goal 1: Reduce health disparities by implementing evidence-based practices that transform VCHCA care for county residents.	**Aim 1:** Health Care Integration	Projects 4.1.1 Health Care Integration, 4.1.2 Primary Care Redesign, 4.1.3 Specialty Care Redesign, 4.2.4 Foster Children
	Aim 2: Care Coordination	Projects 4.1.2 Primary Care Redesign, 4.1.3 Specialty Care Redesign, 4.1.5 Million Hearts, 4.2.2 Care Transitions. 4.2.3 Complex Care, 4.2.4 Foster Children
	Aim 3: Health Inequities	All projects
Goal 2: Reduce cost by improving work flow practices and reducing avoidable utilization.	**Aim 2:** Care Coordination	Projects 4.1.2 Primary Care Redesign, 4.1.3 Specialty Care Redesign, 4.1.5 Million Hearts, 4.2.1 Million Hearts, 4.2.2 Care Transitions, 4.2.3 Complex Care, 4.2.4 Foster Children
	Aim 4: Resource Over-Utilization	Projects 4.1.1 Health Care Integration, Projects 4.1.2 Primary Care Redesign, 4.1.3 Specialty Care Redesign, 4.2.2 Care Transitions, 4.2.3 Complex Care, 4.3.4 Blood Products
	Aim 5: HIT Quality Improvement	4.1.3 Specialty Care Redesign, 4.2.2 Care Transitions, 4.2.3 Complex Care, 4.3.4 Blood Projects
Goal 3: Optimize the use of health information technology (HIT) to enhance quality improvement efforts.	**Aim 4:** Resource Over-Utilization	4.2.2 Care Transitions, 4.2.3 Complex Care, 4.3.4 Blood Products
	Aim 5: HIT Quality Improvement	All projects

** Although there are many overlapping factors that align projects to aims and goals, those listed are the connections that are predominant among the portfolio of interventions.*

Table 5: Ventura County Medical Center and Santa Paula Hospital Medi-Cal Readmissions			
Year	**Readmissions**	**Total Discharges**	**Readmission %**
2013	380	5466	7.0%
2014	570	6304	9.0%
2015	486	6159	7.9%

Table 6: VCHCA and Community Committees with Beneficiary and/or Community Membership that will be Engaged in PRIME Planning/Implementation	
Committees/ Workgroups	**Function**
Breastfeeding Coalition of Ventura County (also see La Leche League)	The Coalition is a nonprofit 501(c)(3) corporation, comprised of health care providers, community leaders, policy makers, and parents, as well as public and private organizations with the common goal of promoting and supporting breastfeeding as the culture norm in Ventura County.
HIV/AIDS Coalition of Ventura County	This committee reports to the Board of Supervisors on the impacts of the HIV/AIDS epidemic and the legal and ethical issues of treating the diseases. Their goal is to minimize the number of new HIV infections and maximize treatment for those with HIV infection.
Ventura County Homeless & Housing Coalition	VCHHC has functioned as the lead planning entity for homeless assistance in the County of Ventura since 1991. It is a non-profit organization whose mission is to develop and maintain a county-wide cooperative effort to address the needs of homeless individuals, those at risk of becoming homeless, and those in need of low-income housing.
La Leche League	All breastfeeding mothers and mothers-to-be interested in breastfeeding are welcome to meetings or call on League Leaders for breastfeeding help or information. Babies are always welcome at meetings. Meetings are facilitated by LLL leaders, experienced mothers who have breastfed their own babies and who have been trained and accredited by La Leche League International to help mothers and mothers-to-be with all aspects of breastfeeding.
Partnership for Healthy Ventura	The Partnership for a Healthy Ventura County is a coalition that includes representatives from Ventura County Public Health, First 5 Ventura County, community organizations, direct health service providers, food security organizations, schools, local area businesses, and government agencies. Representatives come together to share resources and promote policies and services for the sake of a healthy Ventura County. Through its five working committees the HVC Partnership hosts trainings and events throughout the year for health care professionals, employers, teachers, parents, community leaders and seniors to learn about select health and activity related topics.
Prescription Drug and Heroin Workgroup	The Prescription Drug Abuse and Heroin Workgroup was launched in February 2012 in response to the growing problem of prescription pain medication and heroin abuse in Ventura County. Labeled a nationwide crisis and epidemic, reports from professionals and the community made it clear that this region was far from immune. Confronting prescription drug and heroin abuse was essential to protecting the public health and safety of all citizens, including youth

Committees/ Workgroups	Function
Santa Paula Circle of Care	This is a Workgroup established by VCBH with a mission of bringing awareness/working in collaboration with public agencies, community organizations and religious congregations through Santa Paula Circle Of Care (SPCOC) to promote all services to the community especially vulnerable populations.
Las Islas Diabetes Center Education Recognition Program Advisory Board	Recognized by the American Diabetes Association, the group medical visit program offers diabetes education to patients with diabetes, pre-diabetes, and gestational diabetes. The program's Advisory Board includes patients, community outreach workers, local pharmacists, and other members of the community. The board meets annually to ensure that the program meets the needs of the patients and the community.
The Stroke Taskforce – a collaborative with American Heart Association	The EMS Authority staff participated in a Stroke Work Group co-convened by the American Heart & Stroke Association and the California Department of Public Health, Stroke & STEMI Prevention Program. California statute mandates the EMS Authority to adopt necessary regulations to carry out the coordination and integration of all state activities concerning EMS. In addition, State statute allows the EMS Authority to establish guidelines for hospital facilities, in cooperation with affected medical organizations, according to critical care capabilities. As a result of these statutes, the EMS Authority established a multidisciplinary stroke taskforce for the development of STEMI System of Care Regulations for California.
Ventura County Continuum of Care Alliance	The VCCCA is made up of representatives from many public and private organizations including businesses, city departments, corporations, county departments, faith-based agencies, for-profit organizations, neighborhood groups, non-profit organizations, and private foundations.
Ventura County Together	Ventura County Together is a unique collaboration of non-profit agencies, public agencies and community members who came together in 2009 in response to the growing need for basic needs services in Ventura County. Partners are the leading providers of food, shelter and health care for thousands of individuals and families across Ventura County.

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