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**

Table of Contents

Section 1: PRIME Participating Entity Information

Health Care System/Hospital Name

North Sonoma County Healthcare District

Health Care System Designation(DPH or DMPH)

DMPH

Section 2: Organizational and Community Landscape

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

2.1 Community Background.

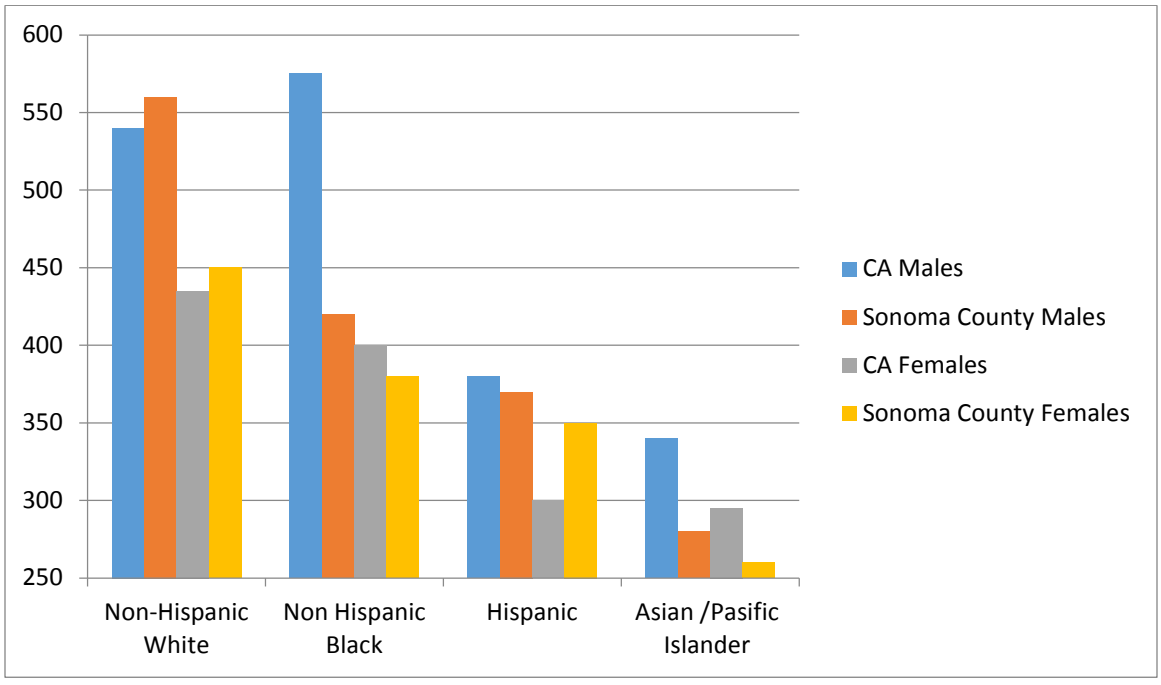
Healdsburg District Hospital (HDH) is a 25-bed critical access hospital (CAH) located in Healdsburg, California in Sonoma County, California. Healdsburg District Hospital serves the communities of Healdsburg, Windsor, Geyserville, and Cloverdale. The community is primarily agricultural with an emphasis on grapes and wine manufacturing. HDH is fully accredited by The Joint Commission and is certified as a primary stroke center. The most significant health issues facing our community include obesity / diabetes, cardiovascular disease and cancer. Health care needs and disparities of our community are summarized below.

Lung, breast, and colorectal cancer.
With the exception of stomach cancer, Sonoma County's all-cancer incidence is higher than the California rate. Research shows that routine screening for certain cancers, including breast, cervical and colorectal cancers, can increase detection at an early and often treatable stage, thereby reducing morbidity and mortality. Lung, breast, and colorectal cancer were identified as priorities because they are significant contributors to morbidity and mortality in Sonoma County and present significant opportunities for early detection through expanded education and screening.

Cancer Incidence Rates for Sonoma County		
Sonoma County Number of New Cancer Cases and Deaths 2011		
	Cases	Deaths
Breast	425	75
Prostate	365	55
Lung &Bronchus	260	225
Colon & Rectum	235	80
Bladder	125	30
All Sites	2470	945
Excludes non-melanoma skin cancers and carcinoma in situ, except bladder.		

Cancer Incidence Rates for Sonoma County						
Males	County Rate	State Rate		Females	County Rate	State Rate
Prostate	147.3	143.3		Breast	142.5	121.6
Lung & Bronchus	59.2	62.0		Lung & Bronchus	51.2	45.0
Colon & Rectum	51.9	50.3		Colon & Rectum	43.1	38.1
Bladder	43.3	33.6		Uterus	25.2	22.1
Melanoma	35.0	26.2		Melanoma	23.6	15.4
All sites	531.2	494.5		All sites	431.8	387.4
Rates are shown as the number of new cases or deaths per 100,000 persons.						

Figure 1 Cancer Rates per Ethnicity



Rates are shown as the number of new cases or deaths per 100,000.

According to the Sonoma County Health and Human Services Agency 5.2% of Sonoma County population have some form of cardiovascular disease.

Cardiovascular disease is grouped into several disorders including disorders of the heart and blood vessels, stroke, elevated blood pressure, heart failure and diabetes Cardiovascular disease is the third leading cause of death for people ages 18-59 in Sonoma County. For residents, age 60 and older, coronary heart disease and stroke are the second and third respectively most common cause of death, behind cancer. Major behavioral contributors to cardiovascular disease include tobacco use, physical inactivity, unhealthy diet, and harmful use of alcohol. According to Sonoma County Community Health Needs Assessment education and prevention efforts targeting these "lifestyle" choices and behaviors should be expanded along with continued emphasis on early detection and management of chronic disease.

The death rate in Sonoma County due to coronary heart disease is 630.2/100,000 people. This number is more than six times the Healthy People 2020 target of 100.8/100,00.people. It is estimated that 47% of Sonoma County residents over 60 have hypertension.

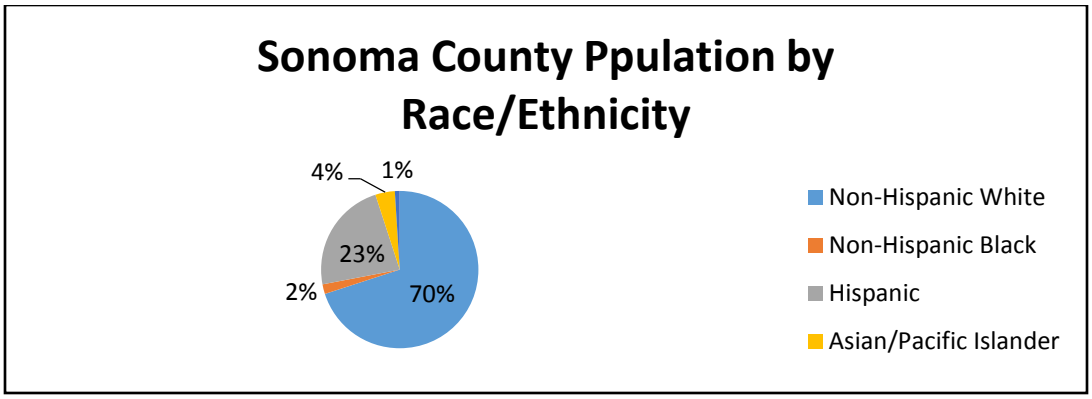
More than 15 % of residents in the District are diabetic with an estimated 49% who are pre-diabetic. It is estimated that 30% of those will be diagnosed with diabetes within 5 years. Fifty-eight percent of residents are obese. Approximately 29% of residents have cardiovascular disease and 44% have or are at risk of acquiring cancer related to lifestyle

Healthy eating and physical fitness.
Poor nutrition and lack of physical activity are driving a national and local obesity epidemic and are contributing to increasing rates chronic disease, disability and premature mortality in Sonoma County. Low-income children and families are especially at risk when they reside in neighborhoods that offer few options to obtain healthy, nutritious food or engage safely in physical activity. Expansion of current efforts in schools and communities to improve nutrition and fitness among youth and adults can help to reduce the growing burden of disease.

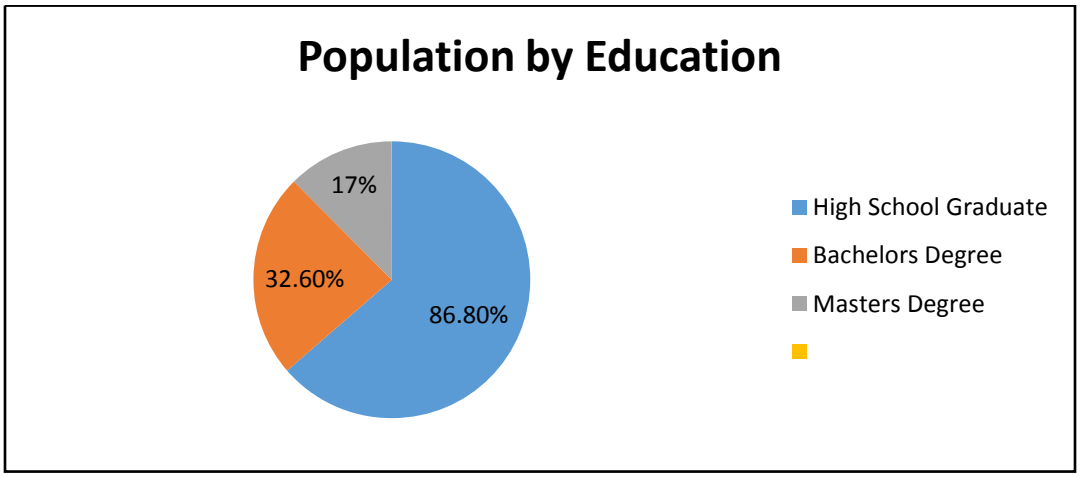
Healdsburg District Hospital would like to utilize the opportunity to participate in PRIME to address the issues identified above.

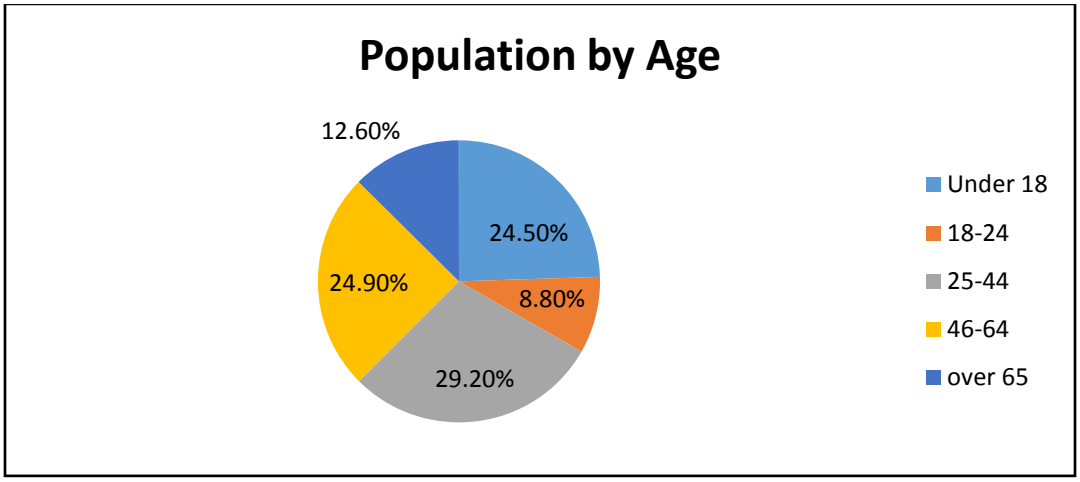
2.2 Population Served Description.

The population of Healdsburg is 11,517; the combined population of areas served is 48,500. The median income is $54,877. The median age is 39.9 years. Thirty-eight percent of the District population identifies as Hispanic and approximately 18% of these residents do not speak any English. The unemployment rate is 5.5%. Approximately 29% of the population has incomes at or below 200% of federal poverty level.



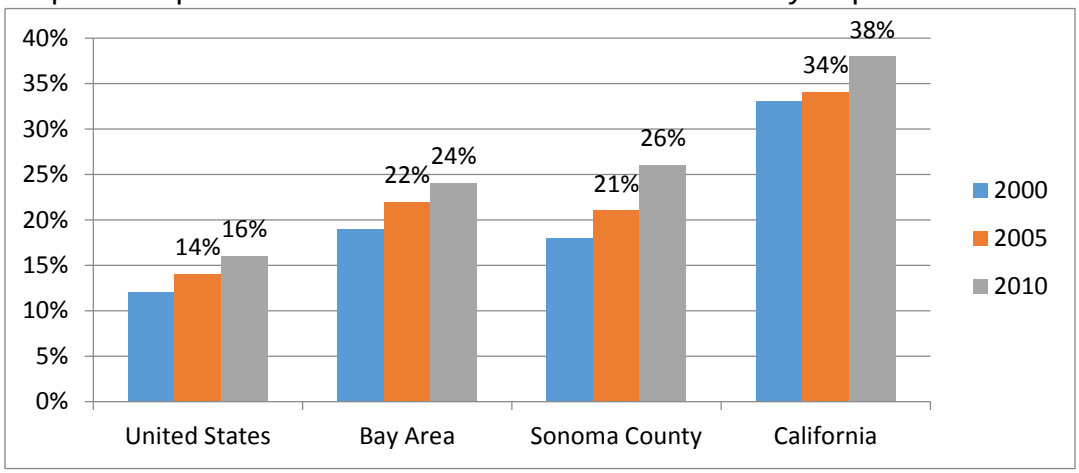
The median age is 38 years. Approximately 25% of the population is under 18 years.Residents18-24 years of age represent 8.8% of the population. Twenty nine point two are between the ages of 25 - 44, 24.9%, are 45 to 64 years of age and is 24.9%, and 12.6% of residents are aged 65 and older. For every 100 females there were 97 males. For every 100 females age 18 and over, there are 94 males.





Our District along with Sonoma County has experienced a demographic shift over the past 20 years. The Hispanic population has grown 300 percent since 1990, now making up 26% of the County's population. It is estimated that by 2060 the Hispanic population will increase by 100,000 people.

Hispanic Population as Percent of Total Sonoma County Population



2.3 Health System Description.

Healdsburg District Hospital is a 25-bed critical access hospital (CAH) providing inpatient, outpatient, surgical, and emergency care as well as diagnostic services. Seventeen beds are general acute care, 4 beds are intensive care, with a 17-bed DP-SNF caring for sub-acute level residents. Healdsburg District Hospital has achieved primary stroke certification. Outpatient clinics include:

- Wound care (hyperbaric services)
- Primary care
- Child / adolescent psychiatry
- Specialty Care
- Physical therapy, occupational therapy, speech therapy
- Occupational health

In fiscal year 2015, HDH's payer mix was 53% Medicare, 34% Medi-Cal, 11% other insurance, and 2% uninsured / indigent care.

2.4 Baseline Data.

Healdsburg District Hospital and the clinics have an electronic health record that is capable of generating reports from the data that is entered on a daily basis. Data is reported and tracked using metrics, benchmarking, and dashboards to demonstrate progress toward goals. These goals are directly related to the strategic plan which is updated and reported to the governing body quarterly. The data analyst develops

reporting tools allowing the HDH leadership to track and promptly identify opportunities for improvement.

The current barrier is the lack of interfaces between the two electronic health record systems i.e., hospital and clinics. The proposed strategy is to purchase and implement interfaces for our current EHR system and activate a bidirectional patient portal. The timeline for implement action of the interface is approximately one year. Vendors have been identified and HDH is in the process of creating an implementation plan.

Healdsburg District Hospital has an active quality assurance and improvement process. These processes are currently in place in the ED, the acute care hospital and the outpatient clinics. Quality data, such as vaccination rates, adherence to clinical protocols and measurement of clinical outcomes is in place. The metrics are reported to the department quality committee, the HDH medical staff and quality review committee, and the governing body. An action plan for corrective action is developed with input from medical staff, nursing staff and the stakeholders to address any metric that is below target or goal. This plan is shared at committee and with the governing body.

The existing lack of interface between the two EHR's will require that manual completion occurs after a report is generated in each system to combine the data in a meaningful way. Healdsburg District Hospital employs a data analyst who will be responsible for this task in coordination with the information technology (IT) department.

Section 3: Executive Summary

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

3.1 PRIME Project Abstract

1. Goals and Objectives

Healdsburg District Hospital's goal is to improve the health of the District by providing high-quality, accessible local healthcare services to all residents of the District and to advocate for the health and wellness of the members of the District. To this end, we are focused on culturally competent population management within the District and participate in a number of initiatives with local health care organizations to realize this goal.

As part of PRIME, HDH will facilitate patients and their families to better manage their health and change their lifestyles to improve healthcare outcomes for the District.

2. Aims

A. Diabetes / Obesity:

Healdsburg District Hospital aims to reduce the morbidity and mortality related to diabetes and obesity through education and a diabetes / obesity and nutrition clinic led by a registered dietician. Healdsburg District Hospital will standardize the approach to diabetes, obesity, and nutrition with evidence-based protocols. Healdsburg District Hospital will develop a centralized complex care management approach to this issue.

B. Cardiovascular:

Healdsburg District Hospital will improve monitoring and treatment of hypertension through a focus on monitoring and standardized treatment based on evidence-based research. Healdsburg District Hospital intends to develop improved remote blood pressure monitoring of residents using available technology.

C. Cancer:

Healdsburg District Hospital will improve screening and early detection of colorectal and breast cancer. The goal for cancer screening is to build into our electronic medical record national guidelines that will alert the physician when a patient is due for screening. Implementation of a strong patient portal will allow information to be readily available to the patient. The patient will be linked with available services in the community through our referral system.

3. Identified Organizational Goals

The projects identified will support integration of care into the community and will assist HDH to provide accessible and local care. Healdsburg District Hospital Selected the Million Hearts Initiative (Project 1.5.2). Cancer Screening Follow up (project 1.6.3) and Obesity Prevention (project 1.7.1) Healdsburg District Hospital chose these projects as they align with our goal of providing preventative care to all patients in our district.

4. Inter-Relatedness

The projects are related to one another in that lifestyle and obesity are directly related to diabetes, cardiovascular disease, and cancer. Healdsburg District Hospital will reorganize and/or develop new delivery of outpatient care models that

are based on care pathways and will improve healthcare outcomes for all residents at risk for chronic disease.

5. Vision

In five years, residents served by HDH will have improved health care outcomes through the use of an enhanced technical infrastructure. The use of the patient portal and remote monitoring of chronic diseases will be optimized to reduce emergency department visits and facilitate patient management of their lifestyles and healthcare outcomes. Electronic interfaces will be built to improve communication to the emergency department and inpatient areas to focus on management of chronic diseases through the continuum of care and to reduce outpatient visits.

3.2 Meeting Community Needs.

Healdsburg District Hospital frequently participates in community events to identify health needs within the North Sonoma County Healthcare District, particularly Sonoma County. Each time we have monitored our community's health needs, we have identified opportunities to meet the needs of special populations including our older adults and marginalized resident within the District. Among the many health disparities, malnutrition affects more than 75% of our community minority population. There are a number of factors that contribute to the risk of obesity, diabetes, and chronic diseases.

Healdsburg District Hospital has identified the role nutrition can have among residents of the District through its needs assessment activities. It is our aim that these efforts will decrease the prevalence of food insecurity among District resident, reducing the risk of poor nutrition and related chronic diseases. Healdsburg District Hospital will achieve this goal by identifying patients at risk for food insecurity upon admission and intake at all HDH locations. Patients will be assessed for both the physical and economic resources to obtain food that meets their dietary requirements. Healdsburg District Hospital will utilize their Health and Wellness team to identify all food banks, meal delivery organizations and access to emergency food sources. This information will be made readily available to the patient in need. Healdsburg District Hospital employs financial counselors that can assist patients with applications to the Cal Fresh program, the special supplemental program for Women, Infants and Children (WIC), and the National School Lunch and School Breakfast Program. According to the Community Health Needs Assessment for Sonoma County enrollment in such programs are underutilized with 63% of those that are eligible have not applied.

3.3 Infrastructure and Alignment with Organizational Goals.

Healdsburg District Hospital developed a PRIME committee with a defined charter to identify the actions to be implemented for the project. Governing body members are publically elected and are committed to the residents of the District. The project is

directly related to the HDH strategic plan that was developed and approved by the governing body. Healdsburg District Hospital leadership is dedicated to improving the healthcare of the District. The PRIME committee meets monthly and recommends infrastructure enhancements to the quality review committee for approval. Members of the quality review committee include physicians, the hospitalist, nursing leaders, and key members of other clinical departments, finance staff, IT staff, and EOC staff. Metrics will be developed for the PRIME project with an identified target/goal. Healdsburg District Hospital reports these metrics using dashboards so that it is immediately obvious those areas with opportunity for improvements. Members of the task force will be assigned to champion these areas and to create an action plan to improve outcomes. A smaller taskforce may be implemented for each area with opportunity for improvement. Ongoing monitoring occurs monthly at the PRIME task force committee and corrective action is identified. Managers and others are responsible for reporting actions to the quality committee. A report is generated for the medical quality review committee; the results are reported to the governing body as a part of the strategic plan.

3.4 Stakeholder Engagement.

Healdsburg District Hospital will ensure that all of NSCHD leadership staff and board members will have multiple opportunities to be engaged in planning and implementation. This will be accomplished by ensuring that members of the administration staff (e.g. the CEO, CNO, CFO, CHRO) and the governing body will serve on the PRIME implementation committee(s). A health care consumer will participate on all PRIME committees. Healdsburg District Hospital will employ the following activities to assure the community and other stakeholders are involved in the planning phases of the project.

- Focus groups for identification of issues and acceptable solutions. Focus groups will be comprised of residents with known diagnoses of lung, colorectal or breast cancer, community physicians, community leaders on health care such as county officials, public health officials and, long term care facilities.
- Use of media, such as radio, newspaper, social media, and flyers to announce programs, education events, and how to access care. Special attention will be paid to the Spanish speaking population; all materials and announcements will be available in Spanish. Local businesses and churches serving Latino groups in the area will be targeted.
- Action plans, clinical protocols, and education programs will be approved by medical staff.
- Information to local physicians and clinics about the PRIME project, its aims, the specific events and programs, and instructions regarding access to activities will be distributed. The physician office staff will be asked to assure it is available to patients at the time of their appointment.

All representatives will serve as voting members of the committee. We will provide the opportunity for questions or comments via our current patient engagement program "*Patient Care Experience".* We have also established relationships with community-

based organizations that provide support services to our patients. Our goal is to continue to engage District residents and NSCHD staff to by developing processes to improve population health

3.5 Cultural Competence and Addressing Health Disparities.

Healdsburg District Hospital has hired staff to reflect the cultural needs of the District. Translation (English –Spanish) is provided on site through a certified interpreter. Spanish speaking registration staff, phone operators, physicians, and other clinical staff are hired in key positons. All written information is available in English and Spanish. Translation for languages other than Spanish is through a paid vendor service that is available 24/7. The patient portal for the EHR is in both Spanish and English. Annual cultural and diversity training is required of all staff and written competencies are maintained.

The following activities will be implemented to support the PRIME project.

- Focus groups for Spanish speaking patients facilitated by a Spanish speaking leader
- Provide all education programs, written materials, and one-on-one counseling in Spanish or with a face-to-face interpreter.
- Assure a Spanish speaking staff member is available at all health fairs and community events focused on PRIME programs.
- Healdsburg District Hospital currently has Spanish speaking staff in all out patient areas, including clinics, clinical laboratory, and radiology (mammography), and provider staff. PRIME programs will include these staff.
- A Spanish speaking dietician and social worker is currently available at HDH. They will assist in the development and implementation of PRIME program and activities.

3.6 Sustainability.

Healdsburg District Hospital has participated in several healthcare improvement initiatives throughout the years, including antibiotic stewardship and the One Hundred Thousand Lives Campaign. Healdsburg District Hospital will use its experience with project management to focus on and successfully implement all aspects of PRIME. This will be accomplished by the following.

- Develop and provide training for all clinical staff on the PRIME project
- Work with the education department to identify gaps in skills and knowledge, then develop a plan to close those gaps
- Involve all physicians and practitioners in the planning and execution of the PRIME project.
- Involve the quality assurance team to strengthen our data driven decision making, also identifying gaps, and creating a plan to close them.

- Involve the IT team to help build and monitor the infrastructure to assure that all information smoothly flows through systems. Create a check and balance systems to assure accurate and timely information flow.
- Engage administration and senior management to support and guide appropriate strategies relating to PRIME project.

Section 4: Project Selection

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

☒ 1.5 – Million Hearts Initiative

Summary:
Healdsburg District Hospital selected project 1.5 because of the high rate of hypertension in the District residents that we serve. Decreasing hypertension in the population served will result in improved healthcare outcomes, such as reduction in stroke or renal disease.

Implementation Approach

Patient Referral and Identification

Healdsburg District Hospital will identify patients through our clinics, emergency department, and inpatients that present with hypertension. In addition, HDH will conduct community clinics at churches, health fairs, and senior centers. The clinics will include screening of blood pressure. As residents with hypertension are identified, HDH will refer them to an existing PCP or provide referrals for those persons without a provider. This will be accomplished during the demonstration year 2016-2017; however outreach will be ongoing.

Clinical Pathways /Protocols

Healdsburg District Hospital will convene a task force to review current screening processes and protocols around treatment and detection of hypertension. The task force will develop common pathways and protocols based on evidence based practice. The task force will be convened during FY 2016-2017. The task force will be responsible for oversight of the entire project and will assure the information and date is disseminated to the stakeholders. The task force will utilize existing data and collect additional data to target and develop preventative and treatment service for all District members. A community member will serve on this taskforce.

Training
The task force will assess the level of education of team members and the community. Primary care providers will be provided a survey to assess their knowledge of current evidence based practice. As gaps are identified, education and training will be developed to meet the needs of the identified group. Patients will also be surveyed and this information will be used to develop patient centered specific education and programs. In addition, HDH will utilize teleconferencing and electronic technology to remotely monitor blood pressure.

Target Population
Heart disease affects all members of the District. However, certain populations are more vulnerable for hypertension and diabetes including the Latino population. The target population will be male and female clients of all ages, including adolescent and teens seen at well visits and for sports physicals. We will identify patients in both the primary care and emergency departments.

Healdsburg District Hospital will hold special screening events for the Latino members of the District at churches, fairs, and retail business in appropriate areas of the community.

Vision for Care Delivery
PRIME will enable HDH to accomplish key strategic objectives that are critical to the health of the District. Hypertension screening will allow HDH to focus on the healthcare needs of all ages (child – adult) in the District, and will target low income and ethnic groups at risk for hypertension and diabetes screening procedures will be identified and implemented; pathways and protocols will be developed to support providers and staff to provide evidence based practice to all residents. Staff will be educated to the cultural needs of the target population.

Healdsburg District Hospital plans to improve our current EHR and build the proper interfaces to accomplish this goal. The focus will be on bidirectional reporting of orders and results including abnormal values. PRIME will assure that HDH is able to accomplish the interface goal.

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

Check, if applicable	Description of Core Components
Not 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.

Check, if applicable	Description of Core Components
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.
Not Applicable	**1.5.3** Improve access to quality care and decrease disparities in the delivery of preventive services.
Not 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.
Not 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.
Not 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.
Not 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.
Not Applicable	**1.5.8** Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.

☒ 1.6 – Cancer Screening and Follow-up

Summary:
Healdsburg District Hospital selected project 1.6 because of the high rate of cancers in Sonoma County including the District residents that we serve. It is our intent to improve diagnosis of cancer at the earliest stage possible for the residents of the District. Healdsburg District Hospital will be able to better guide the patient in early treatment, increase survivability, and improve healthcare outcomes.

Implementation approach

Patient Referral and identification

Healdsburg District Hospital will identify patients through our clinics, emergency room and inpatients that present and meet the criteria for cancer screening. Clinical pathways and protocols will be developed to meet best standard practice for breast, colorectal and cervical cancer. Cancer screening will be ordered at the recommended times and ages by the primary care provider. Results will be followed up by the primary care provider. If a cancer screening result is positive the primary care provider along with the referral specialist will assist in navigating the follow up care needed. Community resources will be identified and utilized when needed. Those resources include, American Cancer Society, Tumor Board, North Bay Cancer Alliance, and Women's Cancer Awareness Group. Healdsburg District Hospital physicians will refer patients to oncology providers in Sonoma County, and if needed will refer to University of California San Francisco Oncology.

Healdsburg District Hospital will conduct community education regarding cancer screenings at churches, health fairs, and senior centers. If persons are identified at risk and do not have a primary care provider, HDH will refer them to a provider. This will be accomplished during the demonstration year 2016-2017; however, outreach and screening will be ongoing.

Clinical Pathways /Protocols

Healdsburg District Hospital will convene a task force to review current screening processes and protocols around cancer prevention. The task force will develop common pathways and protocols based on evidence based practice. The task force will be convened during demonstration year 2016-2017. The task force will be responsible for oversight of the entire project and will assure the information and data is disseminated to the stakeholders. The task force will utilize existing data and collect additional data to target and develop preventative service for all District members. A community member will serve on this task force.

Training

The task force will assess the level of education of team members and the community. Primary care providers will be provided a survey to assess their knowledge of current evidence based practice. As gaps are identified, education and training will be developed to meet the needs of the identified group. Patients will also be surveyed and this information will be used to develop patient centered specific education and programs.

Target Population

Sonoma County has a higher than average cancer rate for the state of California. HDH will follow current CDC and WHO guidelines for cancer screening. These guidelines include

- Breast Cancer Screening every two years for females 40-65 years old with the exclusion of single or bilateral mastectomy.
- Cervical Cancer Screening every three years Females 24-65 years old with the exclusion of hysterectomy or cervical cancer, HIV, HPV, DES exposure.
- Colorectal Cancer Screening, fecal blood occult test done yearly, sigmoidoscopy every 5 years, colonoscopy every 10 years for males and females 50-75 years old. Exclusions include colorectal cancer or total colectomy.

Vision for Care Delivery

PRIME will enable HDH to accomplish key strategic objections that are critical to the health of the district. Cancer screening will allow HDH to focus on the healthcare needs of the identified patients at risk in the District. Screening procedures will be identified and implemented; pathways and protocols will be developed to support providers and staff to provide evidence based practice to all residents. Staff will be educated regarding the needs of the targeted population and related cultural and socioeconomic issues.

Healdsburg District Hospital will improve our current EHR and build the proper interfaces to assure implementation. The focus will be on bidirectional reporting of abnormal test values, orders and results. The patient portal will play a vital role in communication with the patients when various screenings become due. Full implementation of the interface will allow information to flow through all departments as well as to the patient portal, meeting the goals of PRIME. The patient portal has been designed in both English and Spanish.

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

Check, if applicable	Description of Core Components
Not Applicable	**1.6.1** Develop a multi-disciplinary cross-participating PRIME entity task force to identify principle-based expected practices for screening and follow-up for the targeted services including, but not limited to: • Standard approach to screening and follow-up within each DPH/DMPH. • Screening: o Enterprise-wide standard approach to screening (e.g., ages, frequency, diagnostic tool). • Follow-up for abnormal screening exams: o Clinical risk-stratified screening process (e.g., family history, red flags). Timeliness (specific time benchmark for time from abnormal screening exam to diagnostic exam).

Check, if applicable	Description of Core Components
Not Applicable	**1.6.2** Demonstrate patient engagement in the design and implementation of programs.
Applicable	**1.6.3** Collect or use preexisting baseline data on receipt and use of targeted preventive services, including any associated disparities related to race, ethnicity or language need.
Not Applicable	**1.6.4** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to USPSTF A and B Recommendations.
Not Applicable	**1.6.5** Improve access to quality care and decrease disparities in the delivery of preventive services.
Not Applicable	**1.6.6** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
Not Applicable	**1.6.7** Adopt and use certified electronic health record systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population management approaches (e.g., in-reach, outreach) to reduce gaps in receipt of care.
Not Applicable	**1.6.8** Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.
Not Applicable	**1.6.9** Implement a system for continual performance management and rapid cycle improvement that includes feedback from patients, community partners, front line staff, and senior leadership.

☒ 1.7 – Obesity Prevention and Healthier Foods Initiative

Summary:
Healdsburg District Hospital selected project 1.7 because of the prevalence of obesity that is in every community. Obesity is estimated to affect two out of five Sonoma County residents. Healdsburg District Hospital has the ability to reach many patients both in the community and on our primary care panel, to educate

members of the community about the importance of health, weight, dietary habits and an active lifestyle. Healdsburg District Hospital believes by providing early education, and care management that long term health outcomes will improve.

Implementation Approach

Patient Referral and identification

Healdsburg District Hospital will identify patients through our clinics, emergency room and inpatient areas who present with a body mass index both below and above the recommended guidelines. The childhood growth chart and other standardized tests will be utilized to identify children and adolescents.at risk. Education, referrals, coaching and community outreach and follow up will be given those identified. Healdsburg District Hospital will conduct community clinics at churches, health fairs, and senior centers, stressing the importance of healthy weight and healthy food. The clinics will include screening of height and weight on every patient. This will be accomplished during the demonstration year 2016-2017; however outreach and screening will be continuous. Obesity may be more prevalent in certain District ethnic and socioeconomic groups. The Spanish-speaking and Latino population will be targeted for assessment and intervention through screening at churches, fairs, and retail businesses.

A diabetic and obesity clinic will be established with Spanish speaking staff or Spanish interpreter available. This clinic will include a registered dietician, registered nurse, medical provider, and a certified diabetes educator. A social worker and case manager will also be available. The clinic will have a stationary location but will also provide mobile services to better meet the needs of the at risk, vulnerable, and marginalized population in the District.

Clinical Pathways /Protocols

Healdsburg District Hospital will convene a task force to review current screening processes and protocols around treatment and detection of obesity. The task force will develop common pathways and protocols based on evidence based practice. The task force will be convened during FY 2016-2017. The task force will be responsible for oversight of the entire project and will assure the information and date is disseminated to the stakeholders. The task force will utilize existing data and collect additional data to target and develop preventative and treatment service for all District members. A community member will serve on this taskforce.

Training

The task force will assess the level of education of each team member and the community as patient contact occurs. Primary care providers will be provided a survey to assess their knowledge of current evidence based practice. As gaps are identified, education and training will be developed to meet the needs of the

identified group. Patients will also be surveyed and this information will be used to develop patient centered specific education and programs. Surveys will occur in English and Spanish and will be available digitally or on paper.

Target Population

In the primary care setting body mass index screening on all patients will be done at least once a year, unless there has been a 10 pound weight loss or gain; height and weight will then be monitored more frequently. Healdsburg District Hospital will follow guidelines set by the US Preventive Services Task Force for all children. Infants and children will be screened at every visit. Determining factors will include growth chart measurements, evaluation of diet and exercise and family history. In the emergency and inpatient departments a height and weight will be recorded on admission. Data will be obtained from the EHR and concurrent in-depth assessment will occur when possible. A referral to a primary care physician or the diabetes/obesity clinic will be provided for follow up for patients identified as at risk.

Vision for Care Delivery

Prime will enable HDH to accomplish key strategic objections that are critical to the health of the district. Obesity screening will allow HDH to focus on the healthcare needs of all ages (child – adult) in the District. Screening procedures will be identified and implemented; pathways and protocols will be developed to support providers and staff to provide evidence based practice to all residents. Staff will be educated regarding the needs of targeted populations and age related cultural issues.

Healdsburg District Hospital will improve our current EHR and build the proper interfaces to assure implementation. The focus will be on bidirectional reporting of orders and results as well as abnormal values. The patient portal will play a vital role in communication with the patients when various screenings become due. Full implementation of the interface will allow information to flow through all departments as well as to the patient portal, meeting the goals of PRIME.
The patient portal has been designed in both English and Spanish.

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

Check, if applicable	Description of Core Components
Applicable	**1.7.1** Collect or use preexisting baseline data on receipt and use of targeted preventive services, including any associated disparities related to race, ethnicity or language need.

Check, if applicable	Description of Core Components
Not Applicable	**1.7.2** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to USPSTF A and B Recommendations.
Not Applicable	**1.7.3** Improve access to quality care and decrease disparities in the delivery of preventive services.
Not Applicable	**1.7.4** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
Not Applicable	**1.7.5** Adopt and use certified electronic health record systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population management approaches (e.g., in-reach, outreach) to reduce gaps in receipt of care.
Not Applicable	**1.7.6** Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.
Not Applicable	**1.7.7** Implement a system for performance management that includes ambitious targets and feedback from patients, community partners, front line staff, and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology.
Not Applicable	**1.7.8** Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts.
Not Applicable	**1.7.9** Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.
Not Applicable	**1.7.1**0 Prepare for and implement the Partnership for a Healthier America's Hospital Healthier Food Initiative.

Please complete the summary chart:

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

Section 5: Project Metrics and Reporting Requirements

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

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

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

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

Section 6: Data Integrity

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

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

Section 7: Learning Collaborative Participation

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

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

Section 8: Program Incentive Payment Amount

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

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

- DY 11 $ 2,260,000
- DY 12 $ 2,260,000
- DY 13 $ 2,260,000
- DY 14 $ 2,034,000
- DY 15 $ 1,728,900

Total 5-year prime plan incentive amount: $ 10,542,900

Section 9: Health Plan Contract (DPHs Only)

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

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

Section 10: Certification

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

Appendix- Infrastructure Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
1.	Develop a standardized screening procedure for all chosen PRIME measures.	1. Convene a task force to review the literature 2. Develop a standardized procedure 3. Provide education/training to providers and care staff. 4. Work with EHR vendor to develop a bi-directional interface	1.5 1.6 1.7	6/1/2016 – 10/1/2016
2.	Develop and implement clinical and staff education on screening for target measures 1.5, 1.6 and 1.7. All primary care and emergency department physicians will be required to attend clinical measures training and coaching classes. This will include all areas of chosen PRIME projects.	1. Develop curricula modules 2. Develop standard competencies 3. Implement review at yearly evaluations	1.5 1.6 1.7	7/1/2016 - 11/1/2016
3.	Conduct community outreach to capture residents at risk and in need of screening.	1. Develop a task force 2. Assess current resources 3. Conduct community events a. 3 in 2016 calendar year b. 4 in first 6 months of 2017 calendar year	1.5 1.6 1.7	1. 4/30/2016 – 9/30/16 2. 6/1/2016 – 9/30/16 3.a.9/1/2016 – 12/31/16 3.b.12/31/2016 – 12/31/17