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**

Hazel Hawkins Memorial Hospital

Table of Contents

General Instructions 3
Scoring 3
Section 1: PRIME Participating Entity Information 4
Section 2: Organizational and Community Landscape 4
Section 3: Executive Summary 8
Section 4: Project Selection 12
Section 5: Project Metrics and Reporting Requirements 17
Section 6: Data Integrity 18
Section 7: Learning Collaborative Participation 18
Section 8: Program Incentive Payment Amount 19
Section 9: Health Plan Contract (DPHs Only) 19
Section 10: Certification 19
Appendix- Infrastructure Building Process Measures 20

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 Hazel Hawkins Memorial Hospital

Health Care System Designation DMPH

Section 2: Organizational and Community Landscape

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

2.1 Community Background. *[No more than 400 words]*

Drawing on available data (e.g., DHCS, Office of Statewide Health Planning and Development, U.S. Census Bureau), summarize the health care needs and disparities that affect the health of your local community.

Hazel Hawkins Memorial Hospital (HHMH) is located in San Benito County, one of the 4 counties in California with the highest proportion of farmworkers. San Benito County faces unique challenges since a sizable portion of the workforce are farmworkers and thus are more likely to lack health coverage and face financial insecurity.

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

- Obesity/Diabetes: Over 42% of our adult population is obese; this alarming finding contributes to our high incidence of adult diabetes at 17.5% as compared to 8.4% in California. A higher rate of obesity in adults in San Benito County contributes to our high rates of diabetes, hypertension and heart disease.
- Heart Disease: Prevalence of heart disease in San Benito County is the highest in the state at 15.2% compared to 6% statewide. (California Healthcare Foundation)
- Hypertension: This is a leading cause of heart disease, hypertension which occurs in 32.3% of our adult community, compared to 27.2 statewide.

Behavioral Health. Adults needing and receiving behavioral health care services in San Benito County according to the Community Dashboard are: 61% women, 38% men, 57% whites and 40% Hispanics. An immense challenge to the inpatient/emergency room population is the limited access to County Mental Health service, primarily for patients at risk of harm to self or others. Alcohol consumption (34%), illicit drug use (46%), and gang activity (10%) all perform higher than statewide findings, which contributes to higher rates of behavioral health issues.

Health Disparities. Health disparities in San Benito County include higher rates of hypertension, diabetes and obesity in the Hispanic population. Notably, obesity is 42.1% in San Benito County adult Hispanics versus the remainder of the population at 27.9%. Obesity is a serious concern because it is associated with poorer mental health outcomes, reduced quality of life, diabetes, heart disease, stroke, and some types of cancer.

Coverage and Access. San Benito County has over 26,220 Medi-Cal beneficiaries. Patient visits to HHMH rural health clinics totaled 44,909 in Fiscal Year 2015, nearly double (87% increase) from Fiscal Year 2010.

- Adult (18-64) Uninsured: 8,513 residents. (24.1% of total adult population)
  - Hispanic/Latino: 38.69%
  - Non-Hispanic: 35.6%

Adults without any Regular Doctor: 14.69%

When compared to California, San Benito County has significantly higher ratios of population to healthcare providers (3,084 residents: 1 physician, 2,658:1 dentist, 11,104:1 mental healthcare provider).

We are hoping to utilize the opportunity to participate in PRIME to address the issues outlined above.

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.

HHMH serves San Benito County, which is home to 58,267 Californians. Approximately 99% of San Benito County is unincorporated land, with approximately 95% of that land being used for agricultural purposes. San Benito County is home to only two incorporated cities, Hollister, the county seat, which includes nearly two-thirds of the county's population, and San Juan Bautista where Mission San Bautista is located. Travel into Hollister is 20 miles from the US-101 Highway via the 2-lane CA-25 highway

Income.

Median family income: $60,577
Per Capita Income: $25,913

- Hispanic/Latino: $17,745
- Non-Hispanic: $36,698
- Disparity Index: 35.11

Below 100% Federal Poverty Level (FPL): 11.89%
Population below 200% FPL: 32.51%

Race/Ethnicity and Language.

- Population Race/Ethnicity:
  Hispanic: 57.9%   Non-Hispanic: 43.1%
  Black, American Indian, Alaska, Asian and Native Hawaiian other Pacific Islander each represented from nearly one half a percent to 1.6% of the population.
- Language: The primary language is English and the secondary language is Spanish (37%)

Age.

- 0-17: 28.2%   18 – 64: 61.53%   65+: 10.27%

Our County has a lot of farm workers, who are considered a special needs group because the income earned is generally low, job skills are limited, the periods of labor are often seasonal, and the need for housing varies from transitory to permanent. Farm workers may live in substandard housing because of a lack of temporary and permanent housing. The average hourly wage in the Central Coast area for agricultural worker is $8.49 per hour.

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.

The San Benito Health Care District (SBHCD) is a public agency that was founded in 1957 by the voters of San Benito County who were seeking to increase healthcare services for the community.

Hazel Hawkins Memorial Hospital (HHMH) is the primary healthcare provider for San Benito County and the only hospital in the county, a rural and densely agricultural area of central California. The County does not have a dedicated facility for the care of the under insured or uninsured. HHMH is a full service, 62-bed general acute care non-invasive facility with 33 active Medical Staff physicians. HHMH is a designated Rural Hospital by the State of California.

SBHCD currently offers inpatient, outpatient and diagnostic/therapeutic programs. To better serve the community, which often experiences transportation challenges, the SBHCD has created a system of eight clinics in various neighborhood locations. Four (4) clinics are state-designated as a Rural Health Clinic (RHC). Specialties available beside Primary Care are: pediatrics, obstetrics, gynecology, cardiology, general surgery. On a limited basis: pulmonary, infection disease, endocrinology, nephrology, neurology, and gastroenterology.

The role of Hazel Hawkins Memorial Hospital and the larger San Benito Health Care District goes beyond healthcare as the second largest employer in the area with some 76% of our 584 employees residing in San Benito County. For every one hospital job, an additional 1 ½ jobs are created locally.

HHMH's patient population enrolled in government programs is: Medi-Cal 35%, Medicare 39% and uninsured 1.58% for the Fiscal Year 2015, the remaining 25% are Blue Cross, Blue Shield and Commercial payers.

.

The Rural Health and Multi-specialty clinic patient population includes 80.54% covered through Medi-Cal and 5.32% self-pay (no insurance).

2.4 Baseline Data. *[No more than 300 words]*

Describe the current resources that your entity has in place to collect, report and monitor performance data and how these resources will support PRIME clinical quality reporting requirements. Please specify any anticipated limitations or barriers to meeting the PRIME reporting requirements and describe your proposed strategies to address these barriers.

Data Collection. Currently the Quality Department (1.1 FTE) at HHMH collects, analyzes, and reports to our internal stakeholders required regulatory measures and internally / externally developed indicators The reporting structure is designed to eliminate duplication in reporting and collection.

Reporting. Dashboards are utilized to track performance. For example monthly a Quality Assurance/Performance Improvement, readmissions, MediCare utilizations and Emergency Clinical Care dashboard is produced. Quarterly, various reports, such as, departmental performance improvement, physician professional evaluations, risk reports, etc. All reports are determined by stakeholders through the strategic planning process.

Monitoring. Within Acute Care and Emergency Department the current EMR has the ability to capture the multi-morbidity patient to allow measurement and progress towards goals. This process is overseen by the Quality Department.

Barriers. There are several barriers that we will need to overcome to implement our PRIME project. We currently have limited staff resources to measure and report data. Under PRIME, we plan to hire and train staff and create a Chronic Disease Registry to overcome these barriers. This Registry will enable real-time collection, reporting and monitoring of the population served within the Rural Health Clinics. The collection of this valuable data will enable HHMH to analyze and implement appropriate care, programs and expanded services to effectively reduce the disparities within the district, thus optimizing care for our at-risk populations, delivering the highest quality, at the lowest cost, while enriching the patient's experience of care. The major impact for performance improvement is the collection, dissemination, display and analysis of accurate, relevant information of our Target Population.

Section 3: Executive Summary

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

3.1 PRIME Project Abstract [No more than 600 words]

Please address the following components of the Abstract:

1. *Describe the goals* for your 5-year PRIME Plan;*

   Note:

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

HHMH's overarching goal is to improve the health of our patients by managing and coordinating their care. As part of PRIME, we will seek to manage the health of our patients with multiple chronic conditions and thereby reduce avoidable hospital admissions and readmissions.

As part of PRIME, HHMH intends to develop tools and make process changes that lead to greater efficiencies and effectiveness and provide long-term benefits of improved outcomes. The ability to deliver improved outcomes via the Chronic Disease Management Model will allow HHMH and the PRIME Program to thrive in the value-based payment environment that is rapidly evolving. Expansion into chronic disease management will allow for more organized care delivery, better prevention and management of chronic conditions. With expanded care capacity, more patients can have timely access to care, which increases opportunities to prevent disease and treat it early, and patients upon discharge can be scheduled for follow-up appointment and care at the chronic disease clinic, thereby reducing the risk and consequences of worsening health conditions.

Given that the PRIME program is integrated into the strategic plan for the hospital, it will be an area of continued focus for HHMH. We would like to continue to broaden our staff and systems so that we are able to continue to manage a greater number of chronic conditions and patients.

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.*

HHMH has two specific aims: (1) Promote the early detection of chronic diseases and provide education, nutrition and wellness support; and (2) Use technology to monitor patients with chronic conditions in order to deliver efficient and effective care.
The first aim of the HHMH chronic care program is to promote the early detection of chronic diseases, to monitor the health of chronic care patients, to reduce the risk of complications, and to encourage patients to make healthy lifestyle choices that help maximize their quality of life. Chronic care patients are invited to health and wellness classes, one-on-one nutrition and health education counseling, and assistance with medication management and referrals.

As part of the second aim, HHMH will develop a Clinical Information System to collect and organize data to facilitate efficient and effective care by harnessing technology to provide clinicians with an inclusive list (registry) of patients with a given chronic disease. A registry provides the information necessary to monitor patient health status and reduce complications by: providing timely reminders for providers and patients, identifying relevant subpopulations for proactive care, facilitating individual patient care planning, sharing information with patients and providers to coordinate care, and monitoring performance of practice team and care system.

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;*

HHMH selected PRIME Project 2.3 – Complex Care Management for High Risk Medical Populations. This project directly corresponds to our project aims and will enable us to expand the infrastructure needed to develop complex care management services.

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);*

   Not applicable.

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.*

At the end of five years HHMH will have established the infrastructure and staff needed to expand the chronic disease management program from our Rural Health Clinics into

the Specialty clinics and private community providers. Additionally, it will enable us to broaden our capacity to coordinate care for mental health problems, substance abuse and depressive disorders. Furthermore, the PRIME Project will be expanded into the pediatric population for preventative care of pre-diabetes and asthma. As HHMH is the sole healthcare provider in San Benito County, this is imperative for the wide-ranging needs of our community residents.

We predict that with the expansion and training of District-wide care coordination and self-care that is intrinsic to the Project will decrease hospital admissions, readmissions and unnecessary ED use, thus increasing self-management confidence.

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.

Hazel Hawkins Memorial Hospital (HHMH) is committed to improving the health of its patient population as a whole. HHMH will focus its efforts on improving its Care Coordination, Preventative Health and At-Risk Populations based on the health needs and data described in Section 2.1.
Specifically, HHMH will develop a Chronic Care Management Model with an emphasis on the At-Risk Population domain; redesign the primary care delivery system to provide appropriately coordinated care that supports patient self-management; meet accepted evidenced-based disease management guidelines leading to improved health outcomes; meets accepted preventive care indicators; meet accepted patient education indicators and increase shared decision-making. Interactive and consistent education between our care teams and the patient/family will be crucial to our successes and reduction of healthcare disparities, overutilization of the ED, and admissions / readmissions to the hospital.

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).

Our Board of individually elected public officials, Hospital Administration and Directors, created the District Strategic Plan collaboratively. Our goal, first and foremost is to the commitment to the community and beneficiaries we serve. The PRIME Project is strongly integrated into the Strategic Plan, and thusly remains at the forefront of all stakeholders to ensure success.

Executive Leadership is essential to ensure sound health decisions occur for the population and the PRIME Program. Their involvement includes, but is not limited to, the following:

- Appointment of Clinic Medical Director
- Safeguard that Medical Director is aligned with the goals and expectations of the PRIME Project
- Financial oversight of PRIME monies
- Approval of Chronic Disease Clinic Site and expenditures
- Executive oversite of PRIME Committees by way of attendance and receipt of quarterly reports to ensure all milestones of project are met

A PRIME cross-functional team will be assembled to oversee and manage the program with ultimate oversight by the Board. The team will have a vested interest in improving the healthcare disparities within the community and undergo education to attain an understanding of Chronic Disease Management. Responsibilities of the team include assessment of data and outcomes, development/implementation of action plans, assurance that milestones have been met, and reporting monthly progress to all internal stakeholders. Members will include, but are not limited to the following: medical staff, administration, board member, community members / patient, staff, information technology, educator, rural health clinic director and quality director.

This collaboration will be preserved throughout the life of the PRIME program and beyond. As new at-risk populations are identified for inclusion into the Chronic Disease Management milieu, the cross-functional team will develop, measure and report on the evidenced-based quality measures.

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.

To obtained feedback from stakeholders and preserve transparency with our community, HHMH will include a community member / patient as a voting member of our PRIME Project team. Being a District entity, all Board meetings include public comment time that allow for questions /concerns and opportunities for input towards the PRIME Project.

Interfacing with community-based organizations will be an essential responsibility of the assembled Team to ensure these stakeholders have a voice in the development and implementation of the PRIME Project.

3.5 Cultural Competence and Addressing Health Disparities. [No more than 200 words]

Describe planned efforts to ensure cultural competency in implementing PRIME projects and the strategies to reduce healthcare disparities that will be adopted. Identify the resources that the entity has available for this purpose.

The strategic direction at HHMH for PRIME is to serve as a responsive, comprehensive health care resource for low-income / Medi-Cal patients in San Benito County in an effort to continue to meet the health care needs of the community.

A lack of access to care presents barriers to good health, as does language barriers. Receiving education and care in the patients' native language is important to the District and the community. Rates of morbidity, mortality, and emergency hospitalizations can be reduced if community residents access services such as health screenings, disease education and prevention, and healthcare visits in the language / method of their choice. Written materials are provided in both Spanish and English determined by being the primary and secondary languages of the county. All other languages are provided real-time translation through our language interpreter services and/or provider capabilities, including American Sign Language. New hire orientation and annual staff education and training include competencies on cultural sensitive subjects and health disparities.

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.

HHMH is establishing the infrastructure, education and training in order to continue the PRIME project after our five-year participation has ended. We are putting the following elements in place in order to ensure sustainability beyond the five years:

- Customer Focus. Focus on internal and external stakeholders and on meeting or exceeding needs and expectations.
- Employee Empowerment. Involve people at all levels of the organization in education and training, PRIME planning and implementation.
- Leadership Involvement. Strong leadership, direction and support of the PRIME Project by the governing body and CEO are key to assure that PRIME milestones are attained, including implementation.
- Data Informed Practice. Using structure, process and outcome data to inform data-driven decision making and measure results.
- Continuous Improvement. Using Rapid-Cycle Improvement methods, test small incremental changes to achieve measurable impact.

Section 4: Project Selection

The PRIME Projects are organized into three Domains:

- Domain 1: Outpatient Delivery System Transformation and Prevention

- Domain 2: Targeted High Risk or High Cost Populations
- Domain 3: Resource Utilization Efficiency

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

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

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

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

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

Instructions

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

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

1. *Summarize your approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words]*
2. *Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]*
3. ***For DMPHs (as applicable),** indicate which project(s) your entity is selecting that will require infrastructure-building process measures and complete the supplemental document (Appendix) to identify and describe your proposed process measures.*

For DMPHs requiring infrastructure building metrics that are approved in the Prime Project Plan, 75% of PRIME funding for DY 11 will be based on the achievement of the approved DY 11 infrastructure building metrics through the final year-end report. Up to 40% of the total PRIME funding for DY12 will be based on the achievement of the approved DY 12 infrastructure building metrics through the mid-year and final year-end report. The proposed Process Measures should meet the following criteria:

- *Specific*
- *Measurable: Must be able to demonstrate progress throughout the duration of the process metric measurement period.*
- *Evidence-based: Measures should have a strong evidence-base that can linked process to outcomes.*
-

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

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

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]*

Hazel Hawkins Hospital selected PRIME Project 2.3 to help establish a Chronic Disease Center. HHMH rural health clinic patient visits for pulmonary, infection disease, endocrinology, nephrology, neurology, and gastroenterology totaled 44,909 in Fiscal Year 2015, nearly double (87% increase) from Fiscal Year 2010. As described in Section 2.1, the most significant health issues facing our District adults include: obesity, diabetes, hypertension and heart disease.

Our planned approach includes:

Patient Assignment: Establish inclusion and screening criteria for the target population to ensure recognition within the Chronic Disease Registry. The identified patients will be transitioned to the Chronic Disease Center for care. The Registry will embark in DY11.

Population Health Management: To improve practitioner population management, we will implement evidence based guidelines to help providers better manage complex patients. To increase patient's self-efficacy and confidence in their own self-management, we will develop self-management materials in their native language. We

plan on developing this activity in DY 11, followed by implementation and education/training by early DY12.

Complex Care Management / Chronic Disease Center: HHMH plans to implement, a complex care management model for targeted high risk patient populations that facilitates the appropriate coordinated delivery of health care services, meets patient needs and preferences, and improves patient health outcomes. The care team will be trained and educated to the care model/guidelines, management tools and coordination of care in DY 11.

Culturally Competent Care: Staff and providers will be trained to communicate effectively with patients/families in a culturally appropriate manner at a level that the patient/family understands. We plan on working on this activity in DY 11.

Quality Improvement: HHMH will 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. Train and educate in DY 11.

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

Targeted Population. The targeted population for this project is Medi-Cal adult (18+) patients who have had two healthcare encounters in DY12 with a minimum of four of the Districts most predominant chronic conditions. These leading chronic conditions were determined by population evaluation of the rural health clinics, Emergency department and acute care admissions and readmissions, as well as the results of our community needs assessment. Results revealed that our most prevalent chronic conditions include: diabetes, asthma, congestive heart failure, hypertension, chronic renal failure, dementia, and obesity. At the beginning of each Demonstration Year a population evaluation will be conducted to determine additional conditions for inclusion.

Vision for Care Delivery. A Chronic Disease Management program emphasizes the relationship between a patient and their health care provider for accessible, coordinated, comprehensive, and continuous quality health care. A multidisciplinary healthcare team ensures that each patient's preventive, acute, and chronic health care needs are met by using the team to plan, coordinate and manage aspects of their care. The provider and the healthcare team support patients by teaching self-management skills, leading them through the health care delivery system, and showing them how to obtain needed resources and services in the community. The program eliminates healthcare inconsistencies, increases safety, and promotes effective, reasonable, and accessible care.

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.
Not Applicable	**2.3.3** Identify target population(s) and develop program inclusion criteria based on quantitative and qualitative data (e.g., acute care utilization, lack of primary care utilization, number of high-risk medical mental or SUD conditions, polypharmacy, primary care input, functional status, patient activation, social support or other factors). Include patient factors associated with a higher probability of being impacted by complex care management.
Not Applicable	**2.3.4** Conduct a qualitative assessment of high-risk, high-utilizing patients.
Applicable	**2.3.5** Establish data analytics systems using clinical data sources (e.g., EHR, registries), utilization and other available data (e.g., financial, health plan, zip codes), to enable identification of high-risk/rising risk patients for targeted complex care management interventions, including ability to stratify impact by race, ethnicity and language.
Applicable	**2.3.6** Develop a multi-disciplinary care team, to which each participant is assigned, that is tailored to the target population and whose interventions are tiered according to patient level of risk.
Applicable	**2.3.7** Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets.
Not 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).

Check, if applicable	Description of Core Components
	• 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.

Please complete the summary chart:

	For DPHs	For DMPHs
Domain 2 Subtotal # of DPH-Required Projects:		**0**
Domain 2 Subtotal # of Optional Projects (Select At Least 1):		**1**
Domain 2 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 $ 2,620,000
- DY 12 $ 2,620,000
- DY 13 $ 2,620,000
- DY 14 $ 2,358,000
- DY 15 $ 2,004,300

Total 5-year prime plan incentive amount: $ 12,222,300

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.	Organize Medication Reconciliation in the Rural Health Clinic	• Reconciliation of hospital discharge medications with current medication list in the rural health clinic medical record. • Determine number of hospital discharges to rural health clinic with medication reconciliation performed • Conduct medication reconciliation gap analysis • Assess current medication reconciliation rural health clinic pratices for effectiveness. • Develop medication reconciliation protocols for the rural health clinics • Schedule and conduct trainings • Assess effectiveness of training • Pilot the protocols • Implement the protocols • Baseline Zero. Report percentage of Medication Reconciliation documentation in the Rural Health Clinics of patients discharged from the inpatient facility in the last 30 days. Goal is for 10% increase in performance from previous DY.	2.3	January 1, 2016 – December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
2.	Timely Transmission of Transition Record from inpatient facility to Rural Health Clinics	• Formulate continuity in patient's medical care following a hospital discharge by generation of transition record to be delivered to next provider of care within 24 hours of discharge • Develop team of representatives from acute/ED/clinic to design Transition Record • Schedule and conduct trainings • Assess effectiveness of training • Pilot the template • Implement the template • Baseline is zero: Measure Percentage of patients over 18 years of age, for whom a transition record was transmitted to the next provider of care within 24 hours of discharge. Goal is for 10% increase in performance from previous DY	2.3	January 1, 2016 – December 31, 2016
3.	Reduction of Admissions and Readmissions in the ED and Acute Hospital	• Create team-based approach that is patient-centered to reduce admissions / readmissions. • Schedule and conduct trainings of Project RED • Implement Project RED • Baseline is Zero: Measure Percentage, admissions and readmissions of the PRIME Target Population. Goal: 5% decrease in preventable visits from	2.3	July 1,2016 – June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		previous Demonstration Year.		

4.	Create Care Coordinator Assignment	• Establish and support healing relationships, enabled by an integrated clinical environment, characterized by the proactive delivery of evidenced –based care.
		• Hire one (1) Educator / Care Coordinator
		• Define roles among tam members
		  ◦ Develop tools to assist team in caring for these patients: disease registries, reports, brochures, and self-management tools.
		  ◦ Identify PRIME Targeted Population admitted each day to acute care
		  ◦ Concurrent review and interview of admission/readmissions of Targeted Population patients within one (1) business day.
		  ◦ Provide team-based case management serives for PRIME Targeted Population
		  ◦ Monitor performance of team and care systems
		• Baseline is zero: Measure percentage of Target Population with assigned Care Coordinator. Goal: increase of 5% from previous DY.
			2.3	July 1 2016 – June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
5.	Create and convene PRIME project implementation workgroup	• Develop a charter for the workgroup; • Develop list of appropriate hospital staff to participate in workgroup; • Develop list of stakeholders to engage; • Identify patients to participate in projects; • Convene PRIME project implementation workgroup	2.3	January 1, 2016 – June 30, 2016
6.	Conduct workforce and training gap analysis	• Conduct workforce gap analysis; • Review current staffing status; • Identify staffing needs for PRIME projects; • Develop high-level staffing strategy; • Identify training needs	2.3	January 1, 2016 – June 30, 2016
7.	Assess data systems capabilities and needs	• Assess current IT data and reporting systems; • Identify data and reporting needs under PRIME; • Develop a plan for IT and data reporting improvements that need to be made	2.3	January 1, 2016 – June 30, 2016
8.	Develop Chronic Disease Registry	• Assess and determine hospital's current and future capacity and resources needed to operate and sustain a disease registry • Identify and develop cross-functional team to create and implement registry program. Team to include Chronic Disease Center Medical Director and IT staff	2.3	July 1, 2016 – June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Determine desired disease registry functionality (e.g. point of care, outreach, monitoring, population reporting) • Plan, build and implement registry • Determine and incorporate guideline-based patient care algorithms and patient-specific information in registry. • Develop initial baseline reports of that lists patients meeting guideline specifics • Develop population reports that lists patients and user-specified conditions of management control or guidelines regarding compliance status • Educator/Care Coordinator to establish baseline metrics for Target Population • Monitor and report performance on Target Population patients age 18 and older		
9.	Develop Chronic Disease Management Program	• Develop interventions that are geared towards effective management of chronic conditions, health outcomes, self-management and variations in care • Assess effectiveness of self-management, preventions of	2.3	July 1, 2016 – June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		exacerbations and complications by reducing admissions / readmissions. • • Hire one (1) Medical Director and one (1) • Schedule and conduct trainings on interventions • Assess effectiveness of trainings • Implement the Model • Baseline is Zero. Measure PRIME Target Population admissions / readmissions to the Emergency Department and Inpatient care areas. Goal: 5% decrease from previous DY		
10.	Enhance Performance Improvement Capacity	• Implement process improvement methodologies to improve safety, quality and efficiency. • Enhance improvement capacity through technology: design data collection systems to collect real-time data that is used to drive continuous quality improvement • Implement quality improvement data systems, collection and reporting capabilities: generated monthly to measure the impact of the improvement activities.	2.3	July 1, 2016 – June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Create PRIME Quality Dashboard to be disseminated to organizational leadership at all levels on a monthly basis that includes outcome measures. • Schedule and conduct trainings information collection •		
11.	Plan and open Chronic Disease Center	• Plan for location of Chronic Disease Center • Contract with Architect, builder and consultant for project • Construction of new Chronic Disease Center • Obtain Medical licensing & OSHPD approval of new center • Develop marketing materials/ advertisements	2.3	July 1, 2016 – June 30, 2017

12.	Hire and Train Chronic Disease Center Staff	• Complete hiring of clinic staff:
		  • One (1) Medical Director,
		  • One (1) Chronic Disease Educator / Care Coordinators
		  • Two (2) Medical Assistant
		  • One (1) Clerk
		• Write job descriptions / competencies
		• Write Policy and Procedures
		• Create Patient Flow Model
		• Schedule and conduct trainings on policies/
			2.3	July 1, 2016 – June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		procedures, competencies and patient flow model • Pilot the Patient Flow Model • Implement the model		