



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

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

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General Instructions

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

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

Scoring

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

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

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

Section 1: PRIME Participating Entity Information

Health Care System/Hospital Name

John C. Fremont Healthcare District (JCFHD)

Health Care System Designation(DPH or DMPH)

DMPH

Section 2: Organizational and Community Landscape

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

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

John C. Fremont Healthcare District (JCFHD) is located in Mariposa County, a rural county that does not have an incorporated city to date. The community healthcare disparities and health concerns are summarized below.

Physical Health: The most significant health concerns are diabetes and obesity.

- **Diabetes:** Diabetes and complications from diabetes are in the top three diagnosis codes billed from JCFHD. The California state average for age adjusted deaths related to this chronic disease is 20.3%, and Mariposa County ranks 18th with 14.6% (California Department of Public Health, 2013).
- **Obesity:** Obesity in children is on the rise nationally, and 44.7% of Mariposa County seventh graders are overweight or obese (The Lucile Packard Foundation, 2015).

Health Disparities: The most significant health disparities are poverty and lack of access to healthcare. Mariposa County has been designated as a medically underserved area, and JCFHD has been assigned a Health Professional Shortage Area (HPSA) score of 16, indicating that this area does not have enough providers to meet this vulnerable population's needs.

- **Poverty:** According to the United States Census Bureau (2014), 16.2% of Mariposa County's residents are at or below the poverty level compared to 14.5% of the U.S. population.
- **Lack of Access to Healthcare:** Statistics show that 15.6% of the county's population has no healthcare coverage (U.S. Census Bureau, 2014). However, even if individuals were to have insurance and established providers, transportation proves challenging. Only about 2,000 of the county's 17,755 people live in the main township area. Thus, over 15,000 residents require transportation to the hospital and clinics, and no public transportation exists to help individuals get to primary and specialty services appointments. This creates additional complications when the specialists are located out of county.

JCFHD aims to use the PRIME program to provide early recognition of chronic medical conditions, such as diabetes and obesity, improved coordination of care, and enhanced access to care.

2.2 Population Served Description. *[No more than 250 words]*

Mariposa County is small, having a population of 17,755 compared to California's state population of 38,332,521 (United States Census Bureau, 2013). However, the land mass covers 1,448.82 square miles, and JCFHD is the only hospital located in Mariposa County. This makes JCFHD, which is a critical access hospital with rural health clinics, the closest healthcare resource for county residents as it is more than one hour's drive to the closest tertiary care facility.

Income: According to the United States Census Bureau (2014), 16.2% of Mariposa County's residents live at or below the federal poverty level, contrasted with only 14.5% of the national population. Furthermore, the county has an unemployment rate of 8.6%, which is greater than California State's average of 5.7% (Employment Development Department, 2016).

Race/Ethnicity and Language: The population of Mariposa County is predominately white (non-Hispanic/Latino) at 90.2% (United States Census Bureau, 2014). Native Americans make up the next largest group at 3.3%, which is greater than the California and United States averages at 1.7% and 1.2%, respectively (United States Census Bureau, 2014).

Age: The median age for Mariposa County is 49.2 years. The age breakdown is as follows:

- 0-18 years (16.7%)
- 19-64 years (58.8%)
- 65 and over (24.5%)

2.3 Health System Description. *[No more than 250 words]*

JCFHD consists of a critical access hospital with 16 distinct-part skilled nursing beds, 18 swing beds, and a four-bed emergency department as well as diagnostic and outpatient infusion services. The swing beds can serve acute, observation, and short-term rehabilitation patients as well as long term care residents. In addition to the above amenities, JCFHD also provides services in three rural health clinics, two of which deliver primary care and one of which offers specialty care. One of the primary care clinics is located in a remote section of the county, Greely Hill, which allows for easier healthcare access for residents in this isolated area. Fourteen specialists offer services in the specialty clinic located across the street from the hospital, coming monthly to meet with patients. Additionally, JCFHD provides home health, hospice, and private duty services to the community.

The payer mix for JCFHD in fiscal year 2015 was 43.3% Medicare, 17.2% MediCal, 34.4% private insurance, and 5.1% private pay. During this time period, the clinics had 19,158 encounters, while the emergency department had 5,906 visits.

JCFHD has remained a top performer in the California Hospital Engagement Network (CHEN) as well as in Quality Health Indicators (QHi), particularly in the areas of fall prevention, readmissions, and hospital acquired conditions. Furthermore, the emergency department was recognized by BETA Healthcare Group for advancing staff education on the quest for zero harm.

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

JCFHD has a district-wide collaborative approach to performance improvement, incorporating front-line staff and management in the data collection, reporting, and monitoring processes. One person, the Director of Quality, oversees these steps, assembles the information, and reports outcomes to senior leadership and the Board of Directors.

Data Collection: Because of the significant personnel resources involved in performance improvement, JCFHD focuses its energy on addressing national and state mandated core measures and internal patient care and safety issues. Staff at all levels of the district are involved in the data collection step, pulling information from patient surveys, electronic health records (EHR), and community feedback.

Data Reporting: JCFHD, along with other healthcare entities, has discovered that most healthcare quality oversight agencies require the same, or similar, data to be uploaded into different systems. Therefore, senior leadership has worked with these supervisory groups to report shared data where possible. Furthermore, JCFHD utilizes dashboards to report progress on addressing areas of concern to internal stakeholders on a monthly basis.

Data Monitoring: The Director of Quality reviews continually data collection processes and outcomes and looks for further areas of potential improvement.

Challenges to Meeting PRIME Requirements: The most significant barrier to meeting PRIME program requirements is limited staffing: our quality department is currently staffed by one person. Therefore, we anticipate adding at least 0.5 FTE to this department. Another issue may be challenges with culling data from our EHR systems as staff learn the processes for the programs that have recently been implemented in home health, the emergency department, and the clinics. Moreover, the principal EHR used for the district has a primarily manual process of data collection. However, with the addition of appropriate interfaces, JCFHD anticipates that improvements in data collection, reporting, and monitoring will facilitate patient care.

Section 3: Executive Summary

The objective of PRIME is to accelerate participating entities' efforts (as applicable), to change care delivery, to maximize healthcare 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;*

JCFHD's primary goal is to provide quality, evidence-based, patient and family centered care across the health continuum. We are looking toward enhancing population health and access to care.

JCFHD intends to implement technology to allow even the most remotely located patient to receive healthcare. We plan to expand the case management role to assist individuals to navigate complexities of healthcare. This will assure patients and families are receiving appropriate and efficient care to optimize physical and mental health.

Chronic medical conditions, such as diabetes and obesity, can be detected early, managed, and even potentially prevented through use of timely healthcare interventions. By using the PRIME program effectively, JCFHD will provide access to and coordination of services to engender a healthier population.

2. *List specific aims** for your work in PRIME that relate to achieving the stated goals;*

JCFHD has two primary aims for the PRIME plan: (1) to increase access to care in a rural community; and (2) to focus on early diagnosis and treatment of chronic medical conditions, such as diabetes, to avoid unplanned emergency department and inpatient admissions.

To increase access to care, we will be addressing the following interventions.

- Due to the rural population's difficulty with transportation to appointments, JCFHD will be exploring home-based monitoring systems for blood pressures, blood sugars, and other health indicators.
- Furthermore, because many of our residents require specialty services, JCFHD will be examining telemedicine to provide local consultations to reduce clients' transportation obligations.

To improve early diagnosis and treatment of debilitating diseases, we are addressing the following procedures.

- The clinics have initiated installation of a new EHR that will provide reminders for preventative testing and follow-up appointments.

- The new EHR's patient portal will be implemented to allow patients electronic access to their providers for questions, concerns, and advice.
- Our current case management team, which consists of a Registered Nurse and Social Worker, will be enhanced. The expanded patient care team will enable close collaboration between district staff and county public and behavioral health departments as well as patients and their support persons. This will further JCFHD's mission to provide holistic care of our patients.

3. *Provide a statement of how the selected projects will support the identified goals and specific aims. Note that the narrative should connect the specific aims identified in Section 3.1.2 to the projects you select in Section 4. Each project does not require a specific statement. Instead, the narrative in the abstract is broadly linking projects to identified goals and specific aims;*

JCFHD has selected to address Ambulatory Care Redesign: Primary Care (Project 1.2). This project directly involves the goals and aims that JCFHD has established to provide improved access to care and enhanced chronic disease management in our population.

4. *If more than one project is selected, describe how the projects will inter-relate to achieve system transformation (not applicable if only one project is selected); and*

Not Applicable. JCFHD plans to do one project.

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 the five-year PRIME plan, JCFHD anticipates running clinics that manage the unique, patient-centered health needs of each member of our client population. By providing timely access to care as well as efficient chronic disease management in the primary care setting, we will decrease unnecessary and costly emergency department visits and inpatient admissions. Through the PRIME plan, JCFHD will enact the infrastructure and staffing required to meet these goals. Additionally, strengthening our rural population's physical and mental health will further our mission to be the community's choice for healthcare.

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

Redesigning how we deliver primary care in our community will allow for enhanced care coordination for those experiencing chronic diseases, including diabetes and obesity, and healthcare disparities, including poverty and lack of access to services. Because the availability of transportation has proven to be a significant determinant in whether our vulnerable population obtains healthcare, the implementation of technology to provide home monitoring and telemedicine will eliminate some impediments to care. Moreover, the institution of the patient portal for electronic communications between patients and their providers will enhance patient involvement in their care plans. Additionally, expansion of the case management team, in conjunction with telemedicine, will allow for patient and family education and timely management of concerns. This will facilitate improved outcomes and prevent unnecessary emergency department and hospital visits.

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

JCFHD is a district hospital that has a publically elected Board of Directors whose members are all part of the community. Thus, these individuals are aware of the community's needs and the capacities of the district. While providing oversight of JCFHS, the Board of Directors is fully engaged in the stated goals of this PRIME project.

JCFHD has created a committee, including the Chief Nursing Officer, Director of Clinic Operations, and Clinic Nurse Manager. These individuals will provide management of the PRIME program. Committee membership will be expanded as the project moves forward to engage community stakeholders to allow a broader approach to patient centered care. The PRIME project committee will report at the monthly quality improvement meetings to advise front-line staff of plans, developments, and any hurdles. Furthermore, these progress reports will be submitted to the Chief Executive Officer (CEO) and Board of Directors, who are ultimately responsible for the governance of the PRIME program. For example, JCFHD recently implemented a new clinic EHR and the resulting benefits and hurdles are being reported to the quality committee, CEO, and Board of Directors.

3.4 Stakeholder Engagement. [No more than 200 words]

Success with the proposed PRIME project requires that JCFHD engage the community. To address this need, we will provide opportunities for public input and feedback from community members and municipal agencies. This will be done through surveys and public forums. Furthermore, we will seek at least one community member to be part of the PRIME committee. JCFHD has already involved some local and state organizations in addressing continuity of care issues with our patients. For example, Mariposa County Behavioral and Mental Health and Anthem Blue Cross have agreed to assist JCFHD as needed with this project. During the planning and implementation of the PRIME project, we will seek out additional supports and community partners to facilitate the goals of this proposal.

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

JCFHD has embraced diversity and will continue to do so through current practices and ongoing education for staff in cultural competence. Mariposa County, while not particularly racially diverse, does entertain thousands of international tourists. Additionally, there is a prominent, local Native American population. Thus, we are committed to providing culturally competent care and services by using interpreters appropriately, continuing to have a Native American representative on our ethics committee, and inviting a Native American delegate to participate on the PRIME committee.

3.6 Sustainability. [No more than 150 words]

JCFHD has effectively improved patient care in a number of areas, including reducing hospital readmissions and hospital acquired infections. With this experience in change management, we will be successful in the PRIME project using the following strategies.

- Engage providers and front-line staff in the PRIME project and identify clinical and non-clinical champions for the program.
- Ensure community, senior leadership, and Board of Directors support for PRIME interventions.
- Identify learning needs, including deficiencies in knowledge or skills, and develop education to address these gaps.
- Rely on evidence-based practices to support our changes.
- Rely on data to drive processes and outcomes.

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 link process to outcomes.*

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

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

To execute the PRIME project, JCFHD will expand the procedures currently in place to address population healthcare needs and health disparities. JCFHD clinics have the opportunity to be the hub for comprehensive medical services, assisting patients to navigate the complex healthcare system. The following steps will be used to implement this program.

- Assess the engagement, knowledge, and skills of clinical and non-clinical staff through survey questionnaires.
- Identify deficiencies and develop and execute education strategies.
- Enhance data culling, evaluation, and monitoring..
- Expand patient engagement through EHR capabilities (i.e. self scheduling, improving patient provider communication and involving patients in care planning).
- Enhance the case management strategies to improve patient centered care.
-
- Use home monitoring systems and telemedicine to treat at-risk patients following identification of specialty care requirements in the primary care setting..

As the PRIME project is implemented, JCFHD will be able to provide healthcare to even the most remote members of our community. This target population includes those that have limited access and resources to healthcare as well as those at high risk for chronic conditions. The case managers can work with clients to address their specific needs and

barriers, such as lack of insurance and transportation. With telemedicine, clients who may have not sought out care will be able to do so close to home. As the primary care providers assess for risk factors for chronic conditions early on, patient education about chronic diseases will be improved. The team approach to healthcare management will facilitate patient education, support, and guidance to enable clients to avoid, postpone, or self-manage chronic medical conditions. Being in a rural community limits access to care; however, through the PRIME project, JCFHD can enhance the healthcare of this vulnerable population.

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

Check, if applicable	Description of Core Components
Not Applicable	1.2.1 Conduct a gap analysis of practice sites within the DPH/DMPH system.
Not Applicable	1.2.2 Primary care practices will demonstrate advancement of their PCMH transformation through the use of a nationally-recognized PCMH methodology.
Applicable	1.2.3 Hiring and training of frontline workforce (e.g., medical assistants, community health workers, promotoras, health navigators or other non-licensed members of the care team) to be responsible for coordination of non-clinical services and elements of the care plan.
Applicable	1.2.4 Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population/panel management activities, care coordination, patient engagement, and operational and strategic decisions including a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. <ul style="list-style-type: none"> • Implementation of EHR technology that meets meaningful use (MU) standards.
Applicable	1.2.5 Ongoing identification of all patients for population management (including assigned managed care lives): <ul style="list-style-type: none"> • Manage panel size, assignments, and continuity to internal targets. • Develop interventions for targeted patients by condition, risk, and self-management status. • Perform preventive care services including mental health and substance misuse screenings and brief interventions (e.g., PHQ-9, SBIRT).

Check, if applicable	Description of Core Components
Applicable	<p>1.2.6 Enable prompt access to care by:</p> <ul style="list-style-type: none"> • Implementing open or advanced access scheduling. • Creating alternatives to face-to-face provider/patient visits. <p>Assigning frontline workers to assist with care navigation and non-clinical elements of the care plan.</p>
Applicable	<p>1.2.7 Coordinate care across settings:</p> <ul style="list-style-type: none"> • Identification of care coordinators at each primary care site who are responsible for coordinating care within the PCMH as well as with other facilities (e.g., other care coordinators or PCMH/DPH/DMPH high risk care managers): <ul style="list-style-type: none"> ○ Establish onsite care/case managers to work with high risk patients and their care teams, or develop processes for local care coordinators to work with a central complex care management program for these patients <p>Implement processes for timely bi-directional communication and referral to specialty care (including mental health and substance use disorder services), acute care, social services and community-based services.</p>
Applicable	<p>1.2.8 Demonstrate evidence-based preventive and chronic disease management.</p>
Applicable	<p>1.2.9 Improve staff engagement by:</p> <ul style="list-style-type: none"> • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the team-based care model to ensure effective and efficient provision of services (e.g., group visits, medication reconciliation, motivational interviewing, cognitive behavioral therapy and Medication-Assistance Treatment (MAT)).
Applicable	<p>1.2.10 Engage patients using care plans, and self-management education, and through involvement in the design and implementation of this project.</p>

Check, if applicable	Description of Core Components
Not Applicable	<p>1.2.11 Improve the accuracy and completeness of race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI) data, and use that data to identify and reduce disparities in one or more Primary Care Redesign project metrics by:</p> <ul style="list-style-type: none"> • Adding granular REAL and SO/GI data to demographic data collection processes and training front-line/registration staff to gather complete and accurate REAL/SO/GI data. • Developing capacity to track and report REAL/SO/GI data, and data field completeness. • Implementing and/or refining processes for ongoing validation of REAL/SO/GI data. • Developing capacity to stratify performance metrics by REAL/SO/GI data and use stratified performance data to identify disparities for targeted interventions. • Developing capacity to plan and implement disparity reduction interventions with input from patients and community stakeholders. • Developing dashboards to share stratified performance measures with front-line staff, providers, and senior leadership.
Applicable	<p>1.2.12 To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.</p>

Please complete the summary chart:

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

Section 4.3 – Domain 3: Resource Utilization Efficiency

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 \$ 1,500,000.00
- DY 12 \$ 1,500,000.00
- DY 13 \$ 1,500,000.00
- DY 14 \$ 1,350,000.00
- DY 15 \$ 1,147,500.00

Total 5-year prime plan incentive amount: \$ 6,997,500.00

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 care plan for high risk clients using evidence based practices and assign case managers	<ul style="list-style-type: none"> • Convene the PRIME committee adding provider champion • Assess volume and determine staffing needs • Assign clients to a case management team. • Work with EHR vendor to develop care plans for clients. • Work with EHR vendor to develop process to track and follow up on care needs for clients 	1.2.7 1.2.5 1.2.4 1.2.6 1.2.10	July 1, 2016 to June 30, 2017
2.	Redesign case management processes to include referral coordination, home health and behavioral health Assure all staff are engaged and competent in knowledge and skills.	<ul style="list-style-type: none"> • Design case management team to include clinical and non-clinical staff • Develop pre and post assessment modules to determine skill, competency levels and areas requiring additional training. • Develop training modules to provide focused education based on position descriptions. 	1.2.3 1.2.9	July 1, 2016 to June 30, 2017
3.	Develop a plan to provide healthcare to remote members of our community	<ul style="list-style-type: none"> • Work with EHR vendor for client self-scheduling. • Educate staff and clients on procedures. • Consult with IT on tele-medicine equipment. • Obtain tele-medicine equipment • Institute tele-medicine coordinator. • Educate clients on tele-medicine 	1.2.6 1.2.4	July 1, 2016 to June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		<ul style="list-style-type: none"> • Develop process for implementing home medical monitoring 		

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