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

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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 this5-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 10sections 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.

Section 1: PRIME Participating Entity Information

Health Care System/Hospital Name

Mendocino Coast Health Care District/ Mendocino Coast District Hospital

Health Care System Designation (DPH or DMPH)

DMPH

Section 2: Organizational and Community Landscape

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

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

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

Mendocino Coast District Hospital (MCDH) is located in Fort Bragg, CA, the largest city in our health care district.

Physical Health: In Mendocino County from 2007-2009, "Cancer, all causes" was the leading cause of death (22.4% of all deaths).[1] Specifically:

- Breast cancer: The death rate was 27.0/100K population, compared to the statewide average of 21.2.[1] In 2012, there were 62 observed new breast cancer cases in Mendocino County.[2]
- Colorectal cancer: The death rate was 14.9, compared to 14.4 statewide.[1] In 2012, there were 40 observed new cases of colorectal cancer in Mendocino County.[2]
- Cervical/Uterine cancers: Comparable death rate data was not available for the 2007-2009 time period, however Mendocino County saw 19 observed new cases of uterus/cervix cancer in 2012.[2]

Health Disparities: Health disparities in Mendocino County include higher mortality rates for lower income residents. Rates of death increase as poverty increases, and life expectancy is shortest in census tracts with the lowest median household incomes; for every $10,000 increase in median household income, life expectancy rose by 2 years. In our healthcare district, lower household income correlates directly with higher numbers of Hispanic residents.[1]

Another health disparity in California and within our county is the rate at which cancers are detected early in the Hispanic community. Hispanic residents are more likely to have cancers detected at a later stage, when survival rates are lower. For example, 65.3% of Hispanic women receive early detection services for breast cancer vs. 72.3% of White women; 39.8% of Hispanic males receive early detection for colon cancer vs. 42.7% of White men and 40.3% of Hispanic women receive early detection for cervical/uterine cancer vs. 45.5% of White women. The survival rate for all stages of detection with these 3 cancers is 70-91%%, however, survival rates with early detection for these cancers is 92-99%.[2]

Coverage: Mendocino County has 28,727 Medi-Cal beneficiaries as of December 2015, an enrollment increase of 67% over January 2014. A total of 2,004 Medi-Cal beneficiaries were assigned to MCDH's rural health clinic, NCFHC, as of December 2015 (a 111% increase over January 2014)[3].

Data Sources: *Community Health Data 2012*, Mendocino County Health and Human Services Agency, Public Health Branch; and *California Cancer Facts & Figures 2015*, CDPH, California Cancer Registry).

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.

Our district's population is roughly 23,409 (27%) of the county's total population of 87,841. MCDH's 740-square-mile health care district is mostly rural and its population widely dispersed. Fort Bragg, population of 7,250, is the district's largest city.

Income: The median household income within MCDH's district is $41,350, approximately 33% lower than California's median of $61,933.[4] Additionally, 16.7% of our district's households live below the Federal Poverty Level (FPL).[1]

In our five main census tracts, the percent of population living below the FPL directly correlates with percent of population that is Hispanic. The census tract with the lowest median income ($30,702) had the highest percent of Hispanic residents (34.2%), the highest percent living below the FPL (31.0%), and the lowest life expectancy (73.2 years).[1]

Age: The district's population skews older than both the county and the state, with an average age of 48.3 years (compared to 41.5 countywide and 35.2 statewide).[5] Ages break down as follows:

- 0-18: 18.7% (compared to 25% statewide)

- 19-64: 30.9%
- 55-64: 31.9% (critical age range for early cancer detection)
- 65 and older: 18.5% (compared to 11.4% statewide)

Race/Ethnicity: The population of Mendocino County is 68.6% White not Hispanic, 22.2% Hispanic, 4% American Indian, 1.6% Asian/Pacific Islander, 0.6% Black, and 2.8% Mulitrace.[1]

Primary language: English is the primary language spoken in the county. At North Coast Family Health Center (NCFHC) in FY2015 (7/1/14 – 6/30/15), 71.8% of patients named English as their preferred language, while 2.7% listed Spanish, and 25.2% "declined to state/unknown."[6]

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.

MCDH is a full-service 25-bed critical access district hospital, licensed by the State of California Department of Health Services and accredited by The Joint Commission (TJC). Of our 25 beds, we have 4 intensive care beds and 5 perinatal beds. We provide the following services at MCDH: medical/surgical inpatient care, surgery and outpatient surgery, emergency and ambulance services, diagnostic imaging, laboratory, pharmacy, hematology/oncology, cardio/pulmonary, maternity, nutrition, and rehabilitation services.

In addition, MCDH has one rural health clinic, the North Coast Family Health Center (NCFHC), which served 31,107 patient encounters in FY2015. NCFHC provides family practice, internal medicine, pain management, nephrology, wound and ostomy care, pacemaker checks, osteopathic manual therapy, general and orthopedic surgery, podiatry and ophthalmology services. NCFHC is open five days a week.

MCDH also has a Home Health Agency and volunteer Hospice service. The Home Health Agency had a total of 4,635 visits in FY2015.

In FY2015, MCDH had 1,057 acute inpatient admissions, and 95,061 outpatient encounters. The emergency department saw 10,119 visits, of which 684 were admitted, and 184 (26.9%) were NCFHC patients. Average length of stay for acute care was 3.12 days, and hospital beds had a 38% occupancy rate. There were 1,616 ambulance transports.

In FY2015, MCDH's payer mix was: 56.4% Medicare, 23.2% Medi-Cal, 14.9% BlueCross/BlueShield, and 3.3% other indigent care. NCFHC payer mix was: 57.2% Medicare, 18.7% Medi-Cal, 19.2% BlueCross/BlueShield, and 2.8% other.

Overall, 33% of MCDH's revenues came from inpatient services, and 67% of its revenues were from outpatient services.

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.

In FY2015 MCDH launched a quality reporting tool, Healthcare SafetyZone Portal, through Clarity Group, available to all individual department leaders. They create annual performance improvement initiatives based on trends and recommendations from the physician-run Integrated Quality Improvement Committee (IQMC), which reports monthly to the Board of Directors.

Data Collection. Includes but is not limited to the metrics utilized through the Healthcare SafetyZone Portal, manual abstraction, ICD 10 diagnosis codes, clinical claims, pharmacy, etc. MCDH organizes the measures internally. The Quality Risk Manager (QRM) identifies high critical measures that are linked with TJC, CA Department of Public Health, CMS, and the California Maternal Data Center, and manually submits the data through 3rd party vendors.

Last year, NCFHC created a Quality Assurance & Performance Improvement (QAPI) RN position to track quality measures in alignment with Partnership Health Plan's Quality Improvement Program (PHP QIP) and to identify and manage performance improvement projects, which are reported monthly to IQMC.

Monitoring. Our QRM and QAPI RNs review data collection processes and outcomes in an ongoing manner. We have established a process to flag outliers and understand problem areas to develop targeted improvement strategies.

Potential Barriers. The most significant barrier to meeting the PRIME reporting requirements is the small size of our staffing dedicated to data analytics. At this time MCDH has its QRM RN and the rural health clinic's QAPI RN who are responsible for data collection and analysis and reporting. Both positions are limited in the amount of time they can spend on data collection and analysis. Additional FTEs will be hired to fulfill PRIME reporting requirements to include data collection, population health management and care coordination.

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.*

MCDH's overarching goal is to improve the health of our patients by providing culturally competent, evidence-based, standardized, person-centered care. We are moving toward a population health management model and improved care coordination across the patient care continuum.

As part of PRIME, MCDH intends to implement more cost effective and successful approaches to increase the timely receipt of cancer screening and follow-up services for breast, cervical and colorectal cancers, and to reduce variation in approach, performance and disparities of receipt of these services across our population. We intend to detect cancers early thereby increasing relative survival rates for those diagnosed with cancer.

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.*

We have two overarching specific aims for MCDH's PRIME participation: 1) to improve the identification of patients due or overdue for cancer screenings and follow-up care and ensure that they receive timely screenings and follow-up care, resulting in increased rates of early cancer detection, and 2) improve/implement care coordination and population health activities at NCFHC in order to increase rates of early cancer detection and reduce disparities in care.

To achieve these aims, we will:

- More consistently identify patients needing cancer screenings and follow-up through routine use of EHR reports, possibly purchasing our EHR's population health software,
- Standardize our approach to screening and follow-up services,
- Partner with PHP's Physician Recruitment Program to increase access to care,
- Identify cancer resources across MCDH and within the community, and
- Connect patients to needed services through strengthened referral relationships and standardized referral processes.

MCDH anticipates an increase in early cancer detection rates, a reduction in cancer-related deaths and reduced disparities in care.

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;*

MCDH selected the cancer screening and follow-up project (Project 1.1.6), which specifically focuses on screening and follow-up services for breast, cervical and colorectal cancers. This project directly corresponds to our project aims and will enable us to develop the systems needed to implement an improved care coordination and population health model at MCDH.

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*

N/A

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, patients served by MCDH will receive appropriate cancer screenings and follow-up services when they need them, and in the most appropriate and cost-effective care setting. We will have the systems and staffing in place to identify patients in need of cancer screenings and ensure that they receive them, increase rates of early detection, and also ensure timely follow up care that will increase survival rates for those diagnosed with cancer. We also anticipate a decrease in deaths due to cancer.

In addition, we anticipate an improved ability to address preventive health care needs other than cancer with improved use of EHR clinical decision support and registry functionality, and implementation of care coordination and population health management approaches.

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.

As demonstrated in Section 2.1, because cancer is the leading cause of death within our service area, it is vital that MCDH develop an improved approach to identify patients and provide timely cancer screenings and follow-up care. Specifically, enhancing our ability to identify patients who are due or overdue for cancer screenings and developing standardized processes to connect patients with this preventive health care will improve our ability to decrease health disparities. It will also increase the detection of cancers at an early stage, when survival rates are highest.

Improving the organization and delivery of early cancer detection services should address local health needs and improve both health outcomes and the patient experience of care.

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).

MCDH's governance structure reflects our commitment to the communities and patients we serve. As a district hospital, our board members are elected by the public to represent their needs and effectively steward the strategic direction of MCDH. Board members are committed to robust community engagement and oversight of PRIME-related activities.

The Practice Administrator (and PRIME Project Lead) is on the CEO's Executive Leadership Team, which meets 3 times per week. Other members of this team are the Chief of Patient Care Services, the CFO, and the Chief of HR. The team collaboratively selected Project 1.6 and the Practice Administrator reports to the team regularly regarding progress toward PRIME goals, resources needed, etc. The CEO includes PRIME in his District Board report, and the Practice Administrator reports monthly to the Board's Planning Committee.

This project matches MCDH's mission to improve the health of our community, and fits with current strategic plan goals to streamline care, increase access to preventive health services, and continuously improve the quality and patient experience of care. MCDH participates in PHP's Quality Improvement Program (QIP), and its goals addressing colorectal and cervical cancer are aligned with this project's goals.

A steering committee has been formed to oversee PRIME program participation. The steering committee will guide the development of the PRIME plan, recommend to the Board necessary infrastructure investments, and monitor progress toward meeting PRIME goals and performance standards. The steering committee will report to the board's Planning Committee monthly and directly to the Board as needed.

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.

MCDH will ensure that stakeholders and beneficiaries have multiple opportunities to be engaged with PRIME planning and implementation. First, the board's Planning Committee Chair was elected by the community to represent them, and is also a voting member of the board and a healthcare consumer; the Planning Committee Chair will be closely involved with the PRIME steering committee on at least a monthly basis. We will also provide routine opportunities for questions and comments from the public during all Planning Committee and Board meetings to ensure that consumers are able to provide substantive feedback into PRIME-related activities.

We also are strengthening our relationships with the community-based organizations that provide support services to our patients. These stakeholders will be involved as part of PRIME planning and implementation, and may suggest other organizations to be involved in these planning activities.

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.

MCDH has a history of working to meet the diverse needs of our communities. This includes implementing approaches to ensure that providers and staff reflect the diversity of our patients, and that patients have access to health information in the language of their choice. We will continue these efforts to provide culturally competent service and care.

For example, we will continue to provide educational materials in our patients' preferred languages, and provide access to real-time translation services as needed. We currently employ bilingual and bicultural staff and Providers in all areas and jobs within NCFHC (i.e.; phones, front desk, medical assistants, physicians and NPs). Because of our small community, our employees and Providers live in the same cultural environment as our patients. We will partner with the local FQHC, Mendocino Community Clinic (MCC), in cultural competency training, as needed. MCC already has cultural competency training in place. We will also identify Hispanic community groups to partner with in outreach.

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.

MCDH will leverage its experience and training with continuous quality improvement methodologies to sustain PRIME improvements through the use of the following:

- Engaging providers and staff in planning and implementation, including the use of clinical and nonclinical champions,
- Providing intensive education and training, beginning with a process to identify gaps in knowledge and skills and then developing varied learning opportunities to address the gaps,
- Ensuring senior leadership support for designing and implementing strategies to achieve PRIME-related objectives,
- Relying on data-driven decision-making, including the use of population health EHR software, clinical decision support, and automated cancer reporting from NextGen to the California Cancer Registry via the Health Information Exchange (HIE), and
- Developing a population care management approach that we will be able to apply to additional targeted preventive services in the future.

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 (Projects1.1, 1.2, and 1.3 are required);
- Select at least four projects from Domain 2 (Projects 2.1, 2.2, and 2.3 are required); and,
- Select at least one project from Domain 3.

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

Instructions

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

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

1. *Summarize your approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words]*
2. *Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]*

3. ***For DMPHs (as applicable),*** *indicate which project(s) your entity is selecting that will require infrastructure-building process measures and complete the supplemental document (Appendix) to identify and describe your proposed process measures.*

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

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

☒ 1.6 – Cancer Screening and Follow-up

MCDH selected this project because the leading cause of death in Mendocino County is "Cancer, all causes."[1] PRIME will help us to establish a population health management and care coordination model which will enable us to meet our goals stated in Section 3.1. We intend to:

- *Cancer Screening Tools.* Select and implement cancer screening tools based on nationally recognized best practices to be used across the MCDH primary care spectrum. We expect to begin this work in DY11 and complete it in DY12.
- *Care Coordination and Population Health Model.* Develop a care coordination and population health model involving patient care teams in order to capture those patients due or overdue for screenings and follow up services, and design our data collection processes using our certified EHR system. We expect to begin this work in DY11 and complete it in DY12.
- *Staffing.* Develop staffing ratios for each patient care team necessary to meet goals. Develop new job descriptions and training modules. Hire, train and/or retrain patient care staff as needed. We expect to begin this work in DY11 and complete it in DY12.

- *Patient Care Teams.* The implementation of the patient care teams will improve the rate of cancer screenings and follow up, increase the rate of early detection, and decrease the number of deaths due to lack of early detection screenings or delayed follow up. We expect to undertake this work in DY12.
- *Disparities in Care.* Conduct activities to reduce disparities in care through outreach to the Hispanic community. We expect to undertake this work in DY12.
- *Performance Improvement.* Beginning in DY 12 and continuing throughout PRIME, we will implement a system of performance improvement to ensure our model is sustainable and producing the desired outcomes.

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

2. *Target Population.* The target population will be all Medi-Cal patients identified through the cancer screening tools as needing early detection breast, cervical and colorectal cancer screenings and follow up. To reduce disparities in care, we will provide an increased focus on our Hispanic population due to their lower levels of timely screenings and higher levels of cancer-related deaths.

   Vision for Care Delivery. A model involving a patient care team comprised of care coordination and population health resources will improve our ability to capture patients due or overdue for early detection cancer screenings and follow up, thereby reducing preventable breast, colorectal and cervical cancer deaths because early detection did not occur. Our vision includes an enhanced focus on our Hispanic patients in order to reduce disparities in care to this population.

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

Check, if applicable	Description of Core Components
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).

Check, if applicable	Description of Core Components
	• 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).
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.
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.
Applicable	**1.6.5** Improve access to quality care and decrease disparities in the delivery of preventive services.
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.
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.
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.
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.

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):		
Domain 1 Total # of Projects:		

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
- DY 12 $ 1,500,000
- DY 13 $ 1,500,000
- DY 14 $ 1,350,000
- DY 15 $ 1,147,500

Total 5-year prime plan incentive amount: $6,997,500

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

- ✓ **X** 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.	Create & convene PRIME Project implementation committee/workgroup	• Develop a charter • Develop list of appropriate hospital staff to participate • Develop list of stakeholders to engage • Identify patients to participate • Convene workgroup	1.6	January 1 – June 30, 2016
2.	Research & select cancer screening tools for Providers and Care Coordination staff to facilitate increased early detection rates for breast, colorectal and cervical cancers	• Convene an ad hoc clinical workgroup of primary care RNs, NPs & Physicians (may be a subset of the PRIME Project workgroup in Measure 1 above) • Collect & review nationally recognized cancer screening tools & best practices, to include what is available via our EHR & EHR's CDS • Select screening tools	1.6	January 1 – June 30, 2016
3.	Deploy cancer screening tools	• Integrate screening tools into the EHR, if tools selected by the ad hoc workgroup are not already integrated (see Measure 2) • Implement clinical decision support	1.6	June 30, 2016 – June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		(CDS) within EHR which will alert Providers during office visits to order early detection tests if due or overdue • Train Care Coordination staff and Primary Care Providers on the use of the screening tools & CDS and implement the tools/CDS into the Primary Care office visit workflow		
4.	Assess data systems capabilities and needs	• Assess current IT data & reporting systems • Identify data & reporting systems needs under PRIME • Develop a plan for IT and data reporting improvements that need to be made	1.6	January 1 – June 30, 2016
5.	Development of Patient Care Team Model & workforce gap analysis	• Develop a care coordination & population health model involving patient care teams • Determine what the teams should look like – members, structure, etc. • Develop staffing ratios for each team	1.6	January 1, – June 30, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		necessary to meet PRIME goals • Conduct workforce gap analysis • Develop high-level staffing strategy • Identify training needs		
6.	Implementation of Patient Care Teams	• Develop job descriptions • Develop training modules • Recruit and hire new staff • Train new and existing staff • Implement Patient Care Teams	1.6	June 30, 2016 – June 30, 2017
7.	Begin activities to reduce disparities in care	• Identify Hispanic community groups • Coordinate presentations at group meetings to educate them on PRIME Project 1.6 goals, discussing the importance of early detection of breast, cervical and colorectal cancers – if possible, by a bilingual Physician • Explain our cancer prevention services, the availability of bilingual and bicultural staff and bilingual educational materials	1.6	June 30, 2016 – June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Ask groups to advise us on the best way to reach their constituents • Partner with these groups in outreach to the Hispanic population (initial ideas include phone calls, announcements in Hispanic publications, a health fair)		

Appendix- Citations

1. *Community Health Data 2012*, Mendocino County Health and Human Services Agency, Public Health Branch.

2. *California Cancer Facts & Figures 2015*, CDPH, California Cancer Registry.

3. *PHP Southern Region Primary Care Enrollment Jan. 2012 – Dec. 2015,* Partnership Health Plan.

4. American Community Survey (Census ACS), https://www.census.gov/programs-surveys/acs/.

5. *2010 Census Table 1: Population, Age and Sex Characteristics*, California Department of Finance, Demographic Research Unit, State Census Data Center, http://www.dof.ca.gov/research/demographic/state_census_data_center/census_2010/.

6. *North Coast Family Health Center Patient Demographics Report*, NextGen EHR, March 2016.