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

Table of Contents

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

Modoc Medical Center

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.

Currently Modoc County ranks 53 out of 57 counties for overall health outcomes.

Physical Health: The most significant health issues facing our community include adult obesity, colorectal cancer, breast cancer, diabetes, excessive alcohol consumption and adult smoking.

- Adult obesity of 25% compared to the state average of 23%
- Colorectal deaths of an average of 31.5 compared to the state average of 13.9
- Breast cancer deaths of an average of 56.1 compared to the state average of 20.7
- Diabetes deaths of an average of 38.5 compared to the state average of 20.8
- Excessive alcohol consumption of 17% which is in line with the state average of 17%
- Adult smoking of 25% compared to the state average of 23%

Clinical care areas in need of improvement are primary care physicians at a ratio of 3,109:1 compared to the California average of 1,291:1 and preventable hospital stays of 46 compared to the California average of 45.

Behavioral Health: Though no solid data is available for behavioral health issues, historical data from emergency room visits and mental health consults indicate that behavioral health issues along with substance abuse is a real concern for Modoc County. Mental health services are extremely limited in this region. Behavioral health practitioners are at a ratio of 538:1 compared to the state average of 376:1. The clinic currently offers tele-behavioral consults, but more outreach is needed.

Health Disparities: Access to health care for vulnerable populations is the greatest problem facing Modoc County residents. There is also a higher concentration of low socioeconomic demographics and elderly people and persons with disabilities

in this area, resulting in an increase in the need to address chronic conditions. Participating in the PRIME project will allow us to optimize our tracking of health disparities by utilizing technology to measure required metrics.

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.

Modoc County covers 4,256 square miles and had a 2010 population recorded at 9,686 persons (United States Census Bureau, 2014). This rural and remote county has 2.25 persons per square mile which makes Modoc County one of the top three least populated counties in California. This area is not only rural, but considered frontier due to limited access in severe weather and mountainous roadways.

Income: The median income is $36,212 for Modoc County, the lowest of any county in California, with many individuals employed in agriculture and Federal agencies managing the predominately Federal land base in the county. 22.2% of the county's population lives in poverty (United States Census Bureau, 2014). Unemployment for Modoc County is currently 11.7% compared to the California average of 8.9% and children in poverty of 33% compared to the California average of 24%.

Race/Ethnicity and Language: The population is 88.9% White with Hispanics and Native Americans ranking second and third in the remaining population (United States Census Bureau, 2014). The primary language is English at 90.4% and 8.8% of the population identifies Spanish as their primary language.

Age: Modoc County is comprised of 20.5% of the population under 18 years of age compared to the state average of 23.9% and 22.4% 65 years of age or older compared to the state average of 12.5%. This high concentration of elderly residents requires Modoc County to increase resources for those with age related chronic conditions as well as providing greater access to primary care to focus on preventable illness.

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.

Modoc Medical Center (MMC) is a District supported medical facility located in Alturas, California that consists of a 16 bed Critical Access Hospital, a 71 bed Skilled Nursing Facility, Physical Therapy and a Rural Health Clinic. MMC provides a wide range of health services including; acute inpatient care, ambulance services,

cardiac services, diagnostic imaging, emergency room services, laboratory testing, long term care, infusion therapy, outpatient surgical services, physical therapy and rehabilitation, preventative and routine care, swing bed care, and wound care.

Modoc Medical Center Family Practice Clinic (MMCFPC) is located on the campus of MMC in Alturas California. Alturas lies in Modoc County located in the most northeastern corner of California.

The clinic has two physicians and two mid-level providers who provide family practice medical care to patients of all ages including, but not limited to: health maintenance; immunizations; preventative medicine; minor office procedures; well child and adult exams; sports, school, and DMV/DOT physicals; and women's healthcare/family planning.

In addition to the clinic's permanent providers, other providers that practice in our clinic on specific rotations include a registered dietician who provides nutrition consultation services, a podiatrist, and a general surgeon who provides consultations and follow-ups to surgery.
The clinic also delivers behavioral health consults and diabetic education via telemedicine and facilitates referrals to specialty providers in and outside of the immediate community.

The clinic's payer mix currently consists of approximately 32% Medi-Cal, 35% Medicare, 25% commercial insurance, and 8% private- or self-pay.

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.

MMC's current Quality Assurance/Performance Improvement (QAPI) program and structure can accommodate this PRIME project and the data gathering, monitoring, and reporting required to be successful, with some modifications that will be made to facilitate additional reporting as required by this project. The QAPI program encompasses all functions related to improving quality at MMC including collecting data, monitoring and trending that data, forming action plans to improve indicators with assigned teams, modifying those action plans based on results, and reporting the data to appropriate channels within the organization.

Data Collection
MMC Currently has 1 staff position to administer the facility-wide QAPI program. Individual department heads and other members of MMC staff abstract the quality data that is reported through this program.

Reporting
Department heads at MMC establish the indicators they are ongoing to monitor and report each month through MMC's QAPI program. This data is reported to the QAPI Director who then reports it to MMC's Quality Council every other month and to the Board of Directors each quarter.

Monitoring
Each indicator within the QAPI program at MMC is assigned to a team, which is typically comprised of the department head and others they have selected to help them monitor and improve the selected indicator. The team is responsible for monitoring the indicator and initiating plans and processes to improve the indicator's performance. The QAPI Director is responsible for maintaining and updating the plans and process changes that are implemented by the team to improve performance specific to each indicator.

Barriers
MMC currently has limited technology and staff to facilitate the gathering of quality improvement or health outcomes data. Consequently the three largest barriers to gathering, monitoring and reporting data for this project are staff, training, and technology. If we are successful in applying for this opportunity, we intend to hire care coordinators, train them to assist with quality data abstraction and monitoring, and procure technology that will help automate this process so that it is readily accessible and easier to monitor.

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.*

Our PRIME project encompasses various goals that are focused on improving health in Modoc County as follows:

Goal 1: Improve Health Indicators for Modoc County

Through implementation of the PRIME project in the rural health clinic, MMC will improve performance on a number of health indicators for Modoc County. Among those indicators we hope to improve through this project are instance of colorectal deaths, instance of diabetes deaths, adult smoking rates, obesity rates, instance of drug deaths, and others.

Goal 2: Reduce Health Disparities

MMC will also work to reduce health disparities within our community that are related to the socio-economic makeup and age related chronic conditions of the patients in our area. This will be done primarily through ensuring proper and more effective care coordination through qualified staff that can help to educate and follow up with specific segments of our population that experience health disparities in an effort to engage them in their own healthcare to produce better outcomes.

Goal 3: Improve Access to Care

Finally, MMC hopes to improve access to care by changing the way that care is delivered in the clinic, to streamline care delivery and develop workflow that allows our primary care providers to focus on patient care, while passing some of the follow up work off to the team involved in each patient's care. This should allow our providers to see more patients and improve access to primary care in our community.

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.*

MMC has three core aims for PRIME participation as follows:

Aim 1: Develop Necessary Infrastructure to Coordinate Care

Our first aim is to build the infrastructure necessary to sustain care coordination and other activities that we feel will improve the health of our County, as outlined above in our goals. This infrastructure will be utilized to engage patients in their own healthcare at a much deeper level than is currently being accomplished. Within this aim we anticipate accomplishing the following tasks:

- Procure necessary technology to support care coordination and population health management
- Hire and train care coordinators
- Successfully transition the clinic to a PCMH
- Establish a team care delivery model

Aim 2: Identify and Manage Specific Conditions and Populations

Our second aim is to identify and focus care coordination efforts on patients that will influence the health indicators mentioned above in our goals. Identification of those patients utilizing appropriate technology will be incorporated into our care coordination strategy. In addition, the infrastructure above will be utilized to identify and help manage the care of patients that suffer from health disparities within our community.

Aim 3: Stakeholder Buy-In

Our third aim is to gain stakeholder buy in as we implement these changes through PRIME. We have multiple stakeholders in this project including patients, clinic staff, primary care providers, and other agencies that support patients in obtaining resources, education, and healthcare. Engaging these stakeholders in the decision-making process as this project is delivered will help to ensure sustained health system transformation.

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;*

MMC selected Domain1: Outpatient Delivery System Transformation and Prevention project 1.2 Ambulatory Care Redesign: Primary Care. This project directly corresponds to our project aims and will enable us to develop the infrastructure needed to become a Patient Centered Medical Home, implement care coordination, and reduce disparities in healthcare within our community.

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.

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.*

   After five years of participation in PRIME, MMC will have the necessary staff, training and technology to coordinate all aspects of a patient's well-being within a team delivery of care model at the clinic. Successful care coordination will ensure that the most appropriate medical resources are utilized in delivering care to patients at MMC and that the patients that exhibit conditions pertaining to the health indicators and disparities we wish to improve in Modoc County become a healthier segment of our community and realize better health outcomes.

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.

Proper infrastructure, as outlined in section 3.1.2 above, coupled with proper identification of patients that are most likely to influence the health indicators we are aiming to improve, will help us to focus our care coordination efforts on the people that are at highest risk to experience negative health outcomes related to those indicators. Proper follow-up, education, and utilization of other medical resources should help to improve health outcomes for those patients. This should help us to improve the health indicators we intend to focus on during this project.

In addition, establishing a different delivery model in our clinic should help us to gain some capacity to see patients and improve the access that people have to primary care in this area and help to reduce that particular health disparity within our community.

Finally, through PRIME we hope to tailor some of our efforts to the segments of our community that are most likely to be impacted by health disparities, by focusing some of our efforts on Spanish speaking patients and those that are in a lower socioeconomic status (MediCal and Partnership Healthplan of California population). Care coordination efforts and other outreach tools will be utilized to try to steer these patients to the most appropriate medical resources available to them,

reducing overutilization of the Emergency Room and other services that are typically over-utilized by these segments of our population.

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).

MMC's governance strategy is rooted in our commitment to the communities and patients we serve. As a district hospital, our board members are individually-elected public officials. Board members are very knowledgeable about both the healthcare needs of our community and the need to reduce unnecessary utilization. They are also committed to robust engagement and oversight of PRIME-related activities.

MMC has established a PRIME work-group team to begin planning for participation in the new program. Our work-group team will guide the development of the MMC PRIME plan; recommend to the Board necessary infrastructure investments; and, monitor progress toward MMC's efforts to meet its PRIME goals and performance standards.

The existing organizational structure at the clinic will be utilized to oversee care coordinators that are hired as a part of this project. Those care coordinators will be incorporated into the clinic's normal workforce, with direct supervision of those individuals being provided by medical providers and the Clinic Manager. The Clinic Manager is supervised by the Chief Nursing Officer, who will remain involved in high level oversight of this project and will help attain the necessary resources for this project in conjunction with the workgroup.

We expect the PRIME work-group to convene at least monthly in 2016 during the implementation phase. They will, at a minimum, provide a written update to the Board in advance of each Board Meeting and will respond to ad hoc inquiries.

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.

During implementation of its PRIME project MMC will ensure that stakeholders and beneficiaries have multiple opportunities to be engaged in the project's planning and implementation.

In an effort to ensure broad public visibility and availability of information throughout the planning and implementation period, work-group meeting information will be made available on MMC's website and accessible in person. Information provided will include PowerPoints, narratives, meeting agendas, summaries and other critical information.

Patients will be encouraged to provide feedback throughout the project through social media and the website. Patient satisfaction will be measured throughout the project, pre and post-implementation, in an effort to identify areas for improvement.

The testing period will involve a variety of other engagement methods including: group meetings, forums, dissemination of information tailored to specific stakeholders (e.g., reports, data, etc.), and presentations. We will incorporate community-based organizations that provide support services to our patients into PRIME planning and implementation.

Our providers are key stakeholders in this project and their involvement will be solicited in making key decisions, including decisions on team organization and the model that is utilized to redesign care delivery and form care teams, technology solutions needed, skill sets and training needed in care coordinators, process review and establishment of appropriate interventions for specific populations, and other key decisions.

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.

Cultural Competence is currently part of every employee's yearly competency in compliance with JACHO and OSHA standards of yearly employee trainings. This project will require additional training of clinic staff and care coordinators to become aware of health care disparities that exist in our current patient population. This training will allow staff to become aware of the unique health needs of our community and the proper steps needed to address these disparities. Proper care coordination, interventions, population health management tools and technology will be utilized to address health disparities within our community and produce better health outcomes. Two of our providers are bi-lingual in Spanish and English and we also have Spanish versions of handouts and educational materials. Interpreter services are under contract for the entire campus 24 hours a day, 7 days a week. MMC does sponsor a health fair annually that provides services and health screenings to those in our community with a bilingual approach.

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.

MMC participates in a number of quality improvement initiatives and programs including, Medicare Beneficiary Quality Improvement Project (MBQIP), Partnership Healthplan of California quality initiatives for primary care and long-term care, Hospital Quality Institute *Engage* program, and others. Through participation in these initiatives MMC has gained experience that will be leveraged to sustain PRIME improvements through the following activities:

- Engaging providers and staff in planning, key project decisions, and implementation of the project
- Engaging patients in their care through educational and outreach activities
- Identifying educational needs and training staff to appropriate levels to deliver care the way the project outlines
- Relying on data-driven process improvement techniques as currently utilized within the organization
- Obtaining the necessary infrastructure to sustain quality improvement and process changes that will be realized through participation in this project

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

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

MMC selected this project due to the significant need to address the health concerns and disparities of our community such as adult obesity, diabetes, cancer screenings and behavioral health issues. This project will give MMC the infrastructure to identify these needs.

Our planned implementation approach will be:

- *Patient-Centered Medical Home:* Conduct a gap analysis between current practices and PCMH elements to determine what is needed to transition the clinic to a PCMH. We expect to complete this task in DY 11 and continue to improve our clinic PCMH metrics throughout PRIME implementation. We expect to work on this in DY 11-12.
- *Build Workforce Capacity:* Hire and train care coordinators o perform care coordination functions in the clinic. We will identify and implement a care coordination model to achieve workflows and processes around care coordination. We expect to do this in DY 11.
- *Health Technology:* Procure technology that will facilitate care coordination, population health management, quality data gathering, analysis, and monitoring, and implementation of appropriate care interventions. We expect to do this in DY 12.
- *Care Team Delivery Models*: Redesign the way care is delivered and the way that clinic staff interact with the patient to ensure higher efficiency of care delivery, better care coordination, and capability to monitor patients within certain populations and categories of illness to mitigate the potential of poor health outcomes. We expect to do this in DY 12.
- *Stakeholder Engagement:* Maintain engagement of all stakeholders, including patients, providers, and support organizations through active participation in the decision-making process and implementation process. We expect to do this in DY 11.
- *Performance Improvement:* Incorporate project metrics into the overall QA/PI program for MMC. Sustaining PI metrics ensures that improvement of health outcomes becomes a more prevalent component of MMC culture. We expect to do this in DY 12.

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

Target Population. Because of the range of interventions associated with this project, we have identified several target populations. For SBIRT and depression screenings as well as tobacco assessment and counseling, we expect the target population to include all our adult patients. For cancer screening, blood pressure control and IVD screenings, we foresee this to be predominately directed to our older population. We intend to implement this work in our primary care clinic setting. For connecting patients to services, we anticipate that the target population for referral will be a subset of those who have a positive health needs screen and or identification by a provider.

Vision for Care Delivery. Redesigning primary care should increase our capacity to see patients, which will improve access to healthcare. Increasing access to healthcare will be accomplished by implementing advanced scheduling assigning, implementing care teams, implementing technology to support care and engaging patients and staff through involvement in the design and implementation of this project.

With increased patient engagement, care teams that are able to develop effective interventions, proper care coordination, along with technology that facilitates targeting specific patients to accomplish better health outcomes, we are hopeful that this project will help to improve some of the challenges this community faces with healthcare at this time.

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

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

Check, if applicable	Description of Core Components
	leadership. • Implementation of EHR technology that meets meaningful use (MU) standards.
Applicable	**1.2.5** Ongoing identification of all patients for population management (including assigned managed care lives): • Manage panel size, assignments, and continuity to internal targets. • Develop interventions for targeted patients by condition, risk, and self-management status. • Perform preventive care services including mental health and substance misuse screenings and brief interventions (e.g., PHQ-9, SBIRT).
Applicable	**1.2.6** Enable prompt access to care by: • Implementing open or advanced access scheduling. • Creating alternatives to face-to-face provider/patient visits. Assigning frontline workers to assist with care navigation and non-clinical elements of the care plan.
Applicable	**1.2.7** Coordinate care across settings: • Identification of care coordinators at each primary care site who are responsible for coordinating care within the PCMH as well as with other facilities (e.g., other care coordinators or PCMH/DPH/DMPH high risk care managers): o Establish onsite care/case managers to work with high risk patients and their care teams, or develop processes for local care coordinators to work with a central complex care management program for these patients Implement processes for timely bi-directional communication and referral to specialty care (including mental health and substance use disorder services), acute care, social services and community-based services.
Applicable	**1.2.8** Demonstrate evidence-based preventive and chronic disease management.
Applicable	**1.2.9** Improve staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the team-based care model to ensure effective and efficient provision of services (e.g., group visits, medication reconciliation, motivational interviewing, cognitive behavioral therapy and Medication-Assistance Treatment (MAT)).
Applicable	**1.2.10** Engage patients using care plans, and self-management

Check, if applicable	Description of Core Components
	education, and through involvement in the design and implementation of this project.
Not Applicable	**1.2.11** Improve the accuracy and completeness of race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI) data, and use that data to identify and reduce disparities in one or more Primary Care Redesign project metrics by: • Adding granular REAL and SO/GI data to demographic data collection processes and training front-line/registration staff to gather complete and accurate REAL/SO/GI data. • Developing capacity to track and report REAL/SO/GI data, and data field completeness. • Implementing and/or refining processes for ongoing validation of REAL/SO/GI data. • Developing capacity to stratify performance metrics by REAL/SO/GI data and use stratified performance data to identify disparities for targeted interventions. • Developing capacity to plan and implement disparity reduction interventions with input from patients and community stakeholders. • Developing dashboards to share stratified performance measures with front-line staff, providers, and senior leadership.
Applicable	**1.2.12** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

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 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

☒ 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.	Hire and train care coordinators	• Develop job description • Recruit care coordinators • Hire 3 care coordinators • Train Care Coordinators	1.2	07/01/2016-12/31/2016
2.	Acquire the necessary technology to perform care coordination and population health management tasks	• Research and vet viable solutions • Procure technology • Train staff and implement technology • Assess areas for improvement and make necessary changes to technology system functionality • Acquire necessary hardware devices to support identified opportunities for improvement	1.2	07/01/2016-06/30/2017
3.	Achieve PCMH recognition	• Engage consultant to perform gap analysis • Prioritize recommended path to transition to PCMH • Implement necessary step to become PCMH, complete transition	1.2	07/01/2016-12/31/2016
4.	Implement team delivery model	• Research and vet primary care team models to determine care delivery model • Engage providers and other care team members in model selection • Select care team model • Develop policies and procedures for selected care team delivery model • Develop training materials on selected care team delivery model • Train staff on care team delivery model • Implement care delivery model	1.2	07/01/2016-06/30/2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Engage CG-CAHPS consultant • Engage architect/builder to expand/remodel existing clinic space		
5.	EMR review and procurement	• Research and vet current EMRs to support selected care delivery • Procure new EMR technology for the clinic that will support care delivery • Assess areas for improvement and make necessary changes to technology system functionality	1.2	07/01/2016-06/30/2017
6.	Develop access to care strategy	• Convene a workgroup to develop an access to care strategy • Conduct a gap analysis of patient access to care • Review literature and best practices on improving patient access to care • Based on research, develop a strategy to improve access to care	1.2	07/01/2016-12/31/2019