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

PALO VERDE HEALTHCARE DISTRICT

250 N 1st Street

Blythe, CA 92225

REVISED May 17, 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**

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Section 1: PRIME Participating Entity Information

Health Care System/Hospital Name

Palo Verde Healthcare District

Health Care System Designation(DPH or DMPH)

DMPH

Section 2: Organizational and Community Landscape

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

2.1 Community Background. *[No more than 400 words]* 388

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.

Palo Verde Health Care District (PVHD, "the District") is centered in the City of Blythe, Riverside County, on the easternmost border of California. The health care needs and disparities in care of our community are summarized below.

Physical Health. The chronic disease burden in Riverside County is significant, and is also reflected in the PVHD population. 33% of residents report having one chronic condition; 11% report two; and 3% report having three to five chronic conditions.[1] The most significant health issues facing our community are heart disease, COPD, and diabetes.

- Heart Disease: 8% of County residents have heart disease; 30% have hypertension; 37% congestive heart failure[2.] CHF is in the top 10 admission diagnoses at PVHD, and is the primary reason for re-admission.
- COPD: PVHD 2015 data reveals that 1,694 patients were treated for COPD, (1,327 ED; 235 outpatient). Recent reporting on Medicare patients reveals a 27.3% COPD readmission rate within 30 days.[3]
- Diabetes: More than 26% of county residents are obese,[4] contributing to the 9% adult diabetes prevalence rate.[5] PVHD 2015 data reveals that 2,212 individuals received diabetes-related services (861 outpatient, 67 ED).
- Perinatal Care**.** 60% of births in Riverside County are to Hispanic women age 15-44.[6] While County teen births have been on a gradual decline, the PVHD teen birth rate is 4%. Averaging 13 deliveries per month, 50% of PVHD neonates test positive for amphetamines, cocaine and Ecstasy. 9% of PVHD deliveries last year were associated with low birthweight infants, obstetrical complications, postpartum depression, and/or documented issues with parenting in the 0-2 years following birth.

Behavioral Health. Behavioral health issues are also a challenge for the District. 9% of local residents reported serious psychological distress[7]. County residents report having

four (4) poor mental health days per month.[8] 18% of local residents self-report excessive drinking.[9] 25% of residents report insufficient social/emotional support,[10] and are thereby challenged in navigating daily life and maintaining good mental health.

Health Disparities. Riverside County recognizes higher rates of diabetes in African Americans (11%) and Hispanics (10%), than whites (7%).[11] Hispanics experience a higher rate of teen pregnancy than whites.[12] 89% of whites have health insurance coverage, compared with 75% of Hispanics.[13]

Coverage. One-third of the population receives Medi-Cal benefits.[14] Despite recent insurance enrollment efforts, 28% of adults in the Blythe community remain uninsured, as do 10% of children under age 19.[15]

2.2 Population Served Description. *[No more than 250 words]* *215*

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.

The Palo Verde Healthcare District hospital and clinic serve the Blythe community population of 24,390.[16] The region represents a 50:50 urban and rural populations.[17]

Income. The community presents a mixed, but modest economic picture. 30% of families report an annual income of $75,000 or more; however, the per capita income is just $16,450, lower than $23,590 in Riverside County and $29,527 in California. The median income is $53,482.[18] Half of area residents (49.6%) are living in households with income below 200% of the federal poverty level.[19]

Race/Ethnicity/Language. 63% of the local population is white, 13% African American, 2% Asian, 1% American Indian/Alaska Native. Over half (54%) identify as Hispanic. 6% are linguistically isolated, 15% of residents over age 5 demonstrate limited English proficiency, and 45% of the population speaks a language other than English at home. 18% are persons of foreign birth.[20]

Age. Under age 18: 25%. Age 18-64: 66%. Age 65 and over: 9%.[21]

Disabled: Nearly 2,500 people (15%) in the Blythe community identify as disabled.[22]

Social: The unemployment rate is 9%.[23] 15% of residents receive SNAP benefits.[24] One-third of the population has no high school diploma.[25] Public transportation is very limited, and 9% of area residents report having no motor vehicle.[26] 22% of Riverside County residents age 65 or older report living alone.[27]

2.3 Health System Description. *[No more than 250 words]* *248*

Describe the components of your health care system, including license category, bed size, number of clinics, specialties, payer mix, etc.

The District owns and operates Palo Verde Hospital, which is a general acute care district hospital, licensed for 51 acute care beds and designated as the sole community hospital provider. Medical, surgical, and obstetrical services are provided on an inpatient and outpatient basis. Emergency services are provided 24 hours a day, seven days a week. Ancillary services include clinical laboratory, cardiopulmonary and radiology. The hospital employs or contracts with approximately 150 FTE and is non-unionized. The hospital is accredited through Det Norske Veritas (DNV).

PVHD opened a primary care clinic in November 2014 which provides primary care services for patients aged 3 to adult. Services are coordinated by a nurse practitioner, under the direction of a supervising physician. PVHD applied for rural status designation by CMS and CDHP in 2015, and the application is still pending. The primary care clinic currently provides approximately 200 visits per month.

In 2015, PVH processed 1,095 inpatient admissions for a total of 3,586 patient days. Average length of stay was 3.3 days; average daily census was 10. The PVH Emergency Department totaled 10,453 patient visits, and the outpatient clinic supported 1,490 visits. The obstetrical unit performed an average of 13 deliveries per month.

The 2015 PVHD payer mix differs somewhat in the inpatient and outpatient environments, as follows:

- Inpatient: Medicare 48%, Medi-Cal 28%, Access (Arizona Medicaid) 2.5%, 3rd party Commercial 16%, HMO 3.4%. Self-pay 2.2%.
- Outpatient: Medicare 25%, Medi-Cal 34%, Access (Arizona Medicaid) 1.4%, 3rd party Commercial 25%, HMO 2.5%, self pay 12%.

2.4 Baseline Data. *[No more than 300 words]* *287*

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.

Consistent with the DNV accreditation requirements, PVHD has developed a quality management program which is tasked with performance measurement, monitoring, analysis and continuous improvement in performance in order to improve health outcomes and reduce risks for patients.

PVHD's Quality Assurance/Improvement Program includes an ISO component for managing and monitoring business, support and financial systems. Led by the CEO, the Quality team has responsibility for routinely reviewing data on a variety of selected quality and safety metrics to track performance for both hospital and clinic environments. PVHD staff prepares performance reports, including analysis and trended data presentations. Dashboards and other formal reports are presented to internal stakeholders on a monthly basis.

The organization supports multiple technology applications which provide data reporting capability. In May 2016, PVHD will implement a new EHR system, Allscripts, which will be used for clinical documentation and data reporting in all service environments. This will eliminate our current hybrid system and reduce the administrative reporting burden.

PVHD is participating in the Transforming Clinical Practice Initiative, which will provide connection to a national data warehouse through its Lightbeam application. Data reporting will support quality improvement work as the PVHD metrics are shared and benchmarked with national participants.

Potential barriers. PVHD is implementing the Allscripts EHR system in May 2016. As we migrate data from the old system, it is possible that we encounter problems that may take additional time to assure complete and accurate data files. The initial year of the PRIME initiative will be used to fine-tune our data systems and develop the reporting formats for PRIME baseline data reporting. Staff training will be accomplished to ensure proper use of the system for clinical documentation, according to the data field mapping which enables reporting.

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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] 589

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.*

Consistent with the 2016 PVHD strategic plan (see Appendix 3), our organizational goals include:

1. Develop a clinically integrated, patient-centered, cost-effective and financially viable service delivery model that is prepared for the emerging value-based reimbursement strategy through a shared approach to coordinated care management, integrated health information technology, and risk sharing.
2. Adopt a framework for population health management which focuses on prevention, wellness, chronic disease management, integrated health models and new care delivery models outside the walls of the hospital. See Appendix 4 for our Population Health Management approach.

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.*

Through the PRIME initiative, PVHD aims to:

1. Deliver coordinated healthcare services and ensure continuity of care, effectively transferring responsibility to the appropriate healthcare resource

2. Identify and target high risk populations, improve patients' self-care capabilities, and optimize patients' course of chronic illness
3. Develop and integrate new services to support primary care and post-acute care (behavioral health, perinatal care, wound care, home health)
4. Improve physical and behavioral health outcomes, efficiency in care delivery, and patient experience of care, and prevent avoidable ED utilization and hospital admission/readmission.

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;

PVHD selected the integration of primary care and behavioral health (4.1.1), the integration of post-acute care (4.2.2) and complex care management (4.2.3). These directly correspond to our project aims and will enable us to develop the infrastructure needed. The selected projects will act as a catalyst to drive clinical integration between inpatient and outpatient environments, establish proactive communication through new partnerships and technology to ensure comprehensive care management, and, through strategies that engage patients, the community and the healthcare system in changes that will result in effective and efficient systems of care.

A care management program will facilitate seamless transitions of care as patients move between care settings and back into the community. Patients will receive health education and coaching to improve their level of engagement in health care decision-making as well as their confidence in self-care.

Integrated behavioral health services will provide a convenience for the patient, as well as merging the clinical records, improving communication, and strengthening patients' ability for self-care of both physical and mental health issues.

A population health management approach will ensure standardization of care through evidence-based guidelines, and will infuse a culture of quality into care delivery. An enterprise-wide EHR system with embedded decision support will ensure that patients receive the right care at the right time.

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*

The three selected PRIME projects intersect in a number of ways. First, behavioral health services will be interwoven into the primary care setting, providing direct on-site support for individuals with primary mental illness, as well as those with chronic disease who are struggling with behavioral change in order to improve their health status. Screening will be implemented for all patients to identify behavioral/mental health issues early and initiate treatment. Behavioral health interventions will be available to those experiencing substance use disorder, including those in the perinatal period.

Secondly, the bridge between the inpatient and outpatient clinic environments will strengthen support for patients as they transition from one care setting to another. The home health services and wound care services developed in the care transitions project will be available to patients through the primary care clinic as well.

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.*

PVHD anticipates broad-reaching impact spanning patient experience (through integrated care and patient-centered touchpoints), improved clinical outcomes (through motivational interviewing and enhanced patient engagement), and reduced cost of health care by eliminating duplicate testing and preventing avoidable ED utilization and/or hospitalization.

PVHD's transformed delivery system includes a skilled care management team, engaging patients in optimal self-care and providing linkages to community-based organizations. New swing bed capacity will ensure continuity, potentially avoid SNF or hospital care, as well as provide financial stability under the proposed bundled payment system. The EHR system will be a vehicle for population health management, which will feed the quality improvement agenda with data upon which to make decisions about interventions to improve workflows for efficiency and improved clinical outcomes. Access to primary and specialty care will be enhanced, and behavioral health providers will become trusted partners to the primary care teams. PVHD will become the provider of choice and will be recognized as the healthcare anchor in the Blythe community.

3.2 Meeting Community Needs. [No more than 250 words] 248

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.

Enhancing behavioral health services locally will increase the screening for depression and substance use disorders, enabling treatment at the earliest point in time. Recognizing the common co-occurrence of chronic diseases and behavioral health diagnoses, the identification and treatment of behavioral health issues should have a positive impact on our ability to improve health outcomes. Introducing behavioral health into perinatal care will identify substance use issues early, potentially alleviating addiction symptoms in newborns, and provide opportunity to identify and treat postpartum depression.

By improving access to primary care, behavioral health and specialty care, we will alleviate the existing travel burden as patients seek care outside of the PVHD service area. The new home health care service will be popular with patients who lack transportation, have mobility issues, or require an assessment of safety in the home setting; this will reduce the vulnerability of elderly, disabled persons, and/or persons living alone and without transportation.

We also predict improvements in the patients' experience of care. Through effective care management of complex chronic conditions (COPD, CHF, diabetes), we anticipate reduction in avoidable emergency department visits for ambulatory care sensitive conditions. A solid care management program will enable the patients to more confidently manage their own care in the home and community setting, thereby reducing avoidable hospital admissions.

Our participation in the PRIME initiatives will provide a forum for addressing access to preventive care, improving local health literacy, coordinating health care resources throughout the continuum of care, and reducing social barriers which prevent the utilization of needed health care services.

3.3 Infrastructure and Alignment with Organizational Goals. [No more than 250 words] 245

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).

The 2016 PVHD Strategic Plan was adopted by the Board of Directors in January 2016 and incorporates the broad vision for delivery system redesign, including the PRIME projects. Appendix 3 provides a visual display of the PVHD strategic goals for 2016-2018 and their direct alignment with PRIME. As a district hospital, our board members are very knowledgeable about the health care needs of our community; they are committed to robust engagement and oversight of PRIME-related activities.

Led by the PVHD Chief Executive Officer, the PRIME Steering Committee will oversee the work of the individual PRIME projects and review progress routinely. A detailed five-year workplan towards a set of common goals is under development. In addition, the PRIME Steering Committee will review project needs for HIT enhancements, human resources, and community partnership development to ensure success.

Project metrics will be added to the Quality Improvement program umbrella; trended reports will be followed regularly; opportunities for improvement will be identified and interventions designed as appropriate. Data reports will be shared with the clinic teams, the quality improvement committee, the PVHD leadership, and the Board of Directors on a monthly basis.

The clinic's supervising physician will lead the PRIME transformation efforts at the clinic level. The hospital and clinic staff will collaborate on workflow revisions in conjunction with PRIME project goals and use of the new EHR system. The clinic teams will review data and recommend action steps to drive improvement to ensure that PRIME objectives are met.

3.4 Stakeholder Engagement. [No more than 200 words] 164

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.

PVHD will ensure that stakeholders and beneficiaries have multiple opportunities for engagement in PRIME planning and implementation. PVHD Board Meetings are open to the public. Each Board meeting will include a report on the progress of PRIME projects. Public comment will be encouraged, and comments related to the PRIME projects will be relayed to the PRIME Steering Committee.

PVHD will engage the local health care community in planning efforts to ensure that resources are adequate to support the continuum of care. This level of engagement will result in enhanced relationships with the community-based organizations that provide supportive services to our patients.

Additionally, PVHD participates in the Blythe Community Consortium which is comprised of city officials, schools and other partners. This Consortium's input is invaluable in assisting with program development and oversight of current health programs, including the children's diabetic program. This Consortium meets at least once per month and will become a community forum for planning and oversight of the PRIME projects as well.

3.5 Cultural Competence and Addressing Health Disparities. [No more than 200 words] 196

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

The District is committed to ensuring that the needs of our diverse patient population are met, including linguistic and cultural competency. The majority of PVHD staff are bilingual/bicultural, reflecting the community we serve. The clinic Nurse Practitioner is bilingual, as are multiple support positions, ensuring strong communication ability with the Spanish-speaking community. Bilingual personnel provide support for Medicaid enrollment (including a financial counselor). Print materials for eligibility/enrollment are available in English and Spanish (our identified threshold languages), as are health educational materials. PVHD provides real-time access to interpreter services in the patients' language of choice.

In 2015, PVHD received a HRSA grant for a Children's Diabetic Outreach Program using the school-based Bienstar Health Program designed to prevent the development of diabetes in low-income Hispanic children. Through outreach to local schools and recreation centers, PVHD staff conducts screening and multi-cultural learning events for children and parents (also teachers and cafeteria workers) to promote proper nutrition, exercise and diabetes awareness. Through PRIME, parents and families of youth identified at risk will be referred for care management services in the PVHD clinic.

Diabetes awareness events are also held at health fairs and other community events with similar goals.

3.6 Sustainability. [No more than 150 words] 127

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.

PVHD's Quality Management unit utilizes the Plan-Do-Study-Act approach to rapid cycle improvement. This enables process improvement teams to modify workflows to maximize efficiency and improve care delivery processes.

We will leverage the lessons from training on the patient-centered medical home (PCMH) model to improve efficiency, and also deploy a structured care management approach. We will apply population health management techniques which will enhance our quality management efforts and prepare us for active and successful participation in the evolving value-based reimbursement structure.

The PVHD CFO will establish a framework for new reimbursable services developed under the PRIME initiatives, as well as payment enhancements gained through Rural Health Clinic designation. The increased revenue will help us sustain staffing and operational changes made through the PRIME transformation initiatives.

The full engagement of the PVHD leadership team and Board of Directors, the formal updated Strategic Plan, and the organization's quality management structure, will ensure sustainability of the new programs.

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

☒ 1.1 Integration of Physical and Behavioral Health **(required for DPHs)**

Rationale

PVHD's most common behavioral health diagnoses in 2015 were anxiety, depression/mood disorders, alcohol intoxication/abuse, psychosis, and methamphetamine intoxication. Currently, patients seeking behavioral health care come to the Emergency Department(ED); most are brought in by the police on a 5150 hold. The process of finding a psychiatric bed for the patient is arduous. For patients under 18, this task is even more difficult. Recent anecdotes indicate wait times as long as 56 hours for a psychiatric bed.

PVHD is not currently equipped to treat the underlying basis of the abuse, addiction or mental health issues. Considering substance abuse and behavioral health (BH) needs on a short- and long-term basis, PVHD has committed to developing an integrated program for medical and behavioral health care .

Implementation

Palo Verde Hospital will develop behavioral health services for patients through integration and collaboration between its ED, primary care clinic, Riverside County Health Department and other partners as identified. A highly qualified psychiatrist has been engaged to co-lead this endeavor with our clinic supervising MD. Together they will collaborate with our primary care clinicians on adoption of evidence-based protocols and use of appropriate screening tools. Training will be provided to the primary care teams on SBIRT or other methodologies for engaging patients in treatment. The new Allscripts EHR will support clinical documentation including care plan development.

The focus will be multifaceted and include:

- Prevention through identification, screening and early intervention programs in the primary care clinic.
- Establishment of care management and treatment pathways for identified BH issues, including substance use disorder, through on-site services or referral to community BH resources.
- Identifying clinical resources to provide basic treatment and supportive monitoring for behavioral health patients in the emergency department.
- Integrating disposition resources to enhance discharge planning and treatment through an integrated care team.

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

Target Population. For depression screening, PVHD will target all adolescents and all adult patients in both ED and primary care environments. Patients with a positive screen will be referred for formal BH services. Patients deemed in need of a psychiatric hospital bed will be referred for placement.

Vision for Care Delivery.

Enhancing BH services locally will increase routine screening for depression and substance use disorders, enabling treatment at the earliest point in time. Recognizing the common co-occurrence of chronic diseases and BH diagnoses, the identification and treatment of BH issues should have a positive impact on our ability to improve health outcomes for patients with chronic conditions. Introducing behavioral health into perinatal care will identify substance use issues early, potentially alleviating addiction

symptoms in newborns, and provide opportunity to identify and treat postpartum depression.

Behavioral health support in the ED will facilitate timely placement into psychiatric beds, improving the patient experience by eliminating the long hold times in the ED.

Establishing a Care Management protocol will ensure seamless transitions of care through coordination and transfer of newly discharged patients to the most appropriate downstream health care resource. Patients will gain confidence in self-care prior to leaving the hospital to resume care in the community. Strengthening our services in the areas of chronic disease management and wound management will provide patients with a trusted health care resource, promote patient/family understanding of specific disease courses, improve patient engagement in treatment plans, and ultimately improve clinical outcomes, reduce avoidable ED visits and re-admissions.

2. *Infrastructure-building Process Measures* - Yes, see Appendix 2.

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

Check, if applicable	Description of Core Components
Not Applicable	**1.1.1** Implement a behavioral health integration assessment tool (baseline and annual progress measurement)
Not Applicable	**1.1.2** Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration, the Collaborative Care Model, or other Integrated Behavioral Health (IBH) resources from SAMHSA)
Not Applicable	**1.1.3** Integrate appropriate screening tools and decision support into the emergency department (ED) to ensure timely recognition of patients with mental health and substance use disorder problems. Enhanced access to primary care and/or to behavioral health specialists will be integrated into discharge planning for these patents. Use of 24-7 care navigators (e.g., Community Physician Liaison Program) may be used to support linkages to primary care providers (PCPs), mental health (MH) and substance use disorder (SUD) specialists and behavioral health and other community services through the discharge process.

Check, if applicable	Description of Core Components
Applicable	**1.1.4** Integrate physical and behavioral health, either through implementation of a new program or an expansion of an existing program, from pilot sites to hospital and health system primary care sites or from single populations to multiple populations (e.g., obesity, diabetes, maternal, infant, and child care, end-of-life care, chronic pain management).
Applicable	**1.1.5** Patient-Centered Medical Home (PCMH) and behavioral health providers will: • Collaborate on evidence based standards of care including medication management and care engagement processes. • Implement case conferences/consults on patients with complex needs.
Applicable	**1.1.6** Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families.
Applicable	**1.1.7** Ensure systems are in place to support patient linkages to appropriate specialty physical, mental and SUD services. Preventive care screenings, including behavioral health screenings (e.g., PHQ-2, PHQ-9, SBIRT), will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including the provision of brief interventions (e.g., motivational interviewing techniques) to ensure access for further evaluation and treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.
Applicable	**1.1.8** Provide cross-systems training to ensure effective engagement with patients with MH/SUD conditions. Ensure that a sufficient number of providers are trained in SBIRT and/or in other new tools used by providers to ensure effectiveness of treatment.
Not Applicable	**1.1.9** Increase access to Medication Assisted Treatment (MAT) for patients with alcohol and opioid addiction to assist in stabilizing their lives, reducing urges or cravings to use, and encourage greater adherence to treatment for co-morbid medical and behavioral health conditions. For alcohol use disorders these medications include naltrexone, acamprosate, and disulfiram. For opioid addiction, medication assisted treatment (MAT) includes maintenance treatment with methadone and buprenorphine.

Check, if applicable	Description of Core Components
Not Applicable	**1.1.10** Ensure the development of a single treatment plan that includes the patient's behavioral health issues, medical issues, substance abuse, social and cultural and linguistic needs. This includes incorporating traditional medical interventions, as well as non-traditional interventions such as gym memberships, nutrition monitoring, healthy lifestyle coaching, or access to culturally and linguistically appropriate peer-led wellness and symptom management groups.
Applicable	**1.1.11** Ensure a culturally and linguistically appropriate treatment plan by assigning peer providers or other frontline worker to the care team to assist with care navigation, treatment plan development and adherence.
Not Applicable	**1.1.12** Ensure that the treatment plan: • Is maintained in a single shared Electronic Health Record (EHR)/ clinical record that is accessible across the treatment team to ensure coordination of care planning. • Outcomes are evaluated and monitored for quality and safety for each patient.
Not Applicable	**1.1.13** Implement technology enabled data systems to support pre-visit planning, point of care delivery, care plan development, population/panel management activities, coordination and patient engagement. Develop programs to implement telehealth, eReferral/eConsult to enhance access to behavioral health services.
Not Applicable	**1.1.14** Demonstrate patient engagement in the design and implementation of the project.
Not Applicable	**1.1.15** Increase team 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 care model.
Not Applicable	**1.1.16** Ensure integration is efficient and providing value to patients by implementing 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 4.2 -- Domain 2: Targeted High-Risk or High-Cost Populations

☒ 2.2 – Care Transitions: Integration of Post-Acute Care **(required for DPHs)**

Rationale:

The District faces significant challenges along the continuum of care: 1) difficulty obtaining post-acute care services for the increasing Medi-Cal population; 2) a high readmission rate; 3) the lack of adequate community health care resources to support patients upon discharge.

PVHD admissions data reveals the majority of patients are treated for cellulitis, abscesses and vascular issues. Some of these are related to diabetes and neuropathy; others to desert insect bites. PVHD's 30-day all-cause readmission rate was 22.7% (Q12015).[28] 52% of patients receiving post-discharge follow-up were readmitted within 30 days, and most occurred in the now-at-home group of patients.[29]

None of the local home health agencies accept Medi-Cal patients. Riverside County provides In-Home Supportive Services (IHSS), but these are sparse in the rural community of Blythe.

These issues demonstrate a clear need for a focused care transitions program, supportive care management and home health services for patients in the PVHD community.

Implementation Plan

PVHD's existing RN Care Manager will collaborate with the clinic-based RN Care Coordinator on transitions of care. They will ensure that necessary health care resources are available and provided in a timely manner.

The newly available swing beds will enable seamless care transitions for those patients requiring short intervals of nursing support post discharge. These beds will also be used as a brief stay venue for intravenous administration of antibiotics. A specialty wound care service, will ensure wound healing. In addition, this service will help patients avoid costlier SNF placement, ED visits and hospitalizations.

PVHD will develop a clinic-based home health service program to provide complex care management, oxygen therapy, instruction on use of exercise equipment, wound assessment, medication management, home safety assessment, as well as self-

management education that will build confidence in the patient's ability for successful self-care.in the home and community.

1. *Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]* *231*

Target Population. The target population will be patients discharged from PVHD, with a heightened focus on those with chronic disease and those requiring wound management. An evidence-based assessment tool will be utilized to identify individuals with a high risk for readmission; criteria will include frequency of ED/hospitalization events. Medi-Cal eligible patients at high risk for readmission will be a primary focus to facilitate appropriate and timely post-discharge follow-up and referral to community resources. PVHD's new complex care management services, including home care and wound care services will provide needed support to patients and help to avoid unnecessary emergency department visits and hospitalizations/readmissions.

Vision for Care Delivery. A care management approach to transitions of care will result in the coordination of health care resources for patients, improve the patient's experience of care, and ensure safety for the patient. These efforts will contribute to improved clinical outcomes as well.

Using population health management principles, the PVHD clinical team will be able to fortify their outreach and follow-up of transitional patients. Through focused health education, coaching, and personal goal setting techniques, the PVHD team can more effectively motivate patients towards successful self-management while in the home and community.

The introduction of wound therapy services (including home care) in the Blythe community will fill a needed gap for those requiring support for wound management and may potentially avoid more costly inpatient or interval residential care.

2. *Infrastructure-building Process Measures* - Yes, see Appendix 2.

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

Check, if applicable	Description of Core Components
Applicable	**2.2.1** Develop a care transitions program or expand a care transitions program to additional settings (e.g., emergency department), or to additional populations, using or adapting at least one nationally recognized care transitions program methodology.

Check, if applicable	Description of Core Components
Applicable	**2.2.2** Establish or expand on a system to track and report readmission rates, timeliness of discharge summaries, and other transition processes, and investigate system-specific root causes/risk factors for readmission, using quantitative and qualitative information to identify the key causes of readmissions, including physical, behavioral and social factors.
Applicable	**2.2.3** Develop and implement a process, including utilization of data and information technology, to reliably identify hospitalized patients at high-risk for readmission.
Not Applicable	**2.2.4** Develop standardized workflows for inpatient discharge care: • Optimize hospital discharge planning and medication management for all hospitalized patients. • Implement structure for obtaining best possible medication history and for assessing medication reconciliation accuracy. • Develop and use standardized process for transitioning patients to sub-acute and long term care facilities. • Provide tiered, multi-disciplinary interventions according to level of risk: o Involve mental health, substance use, pharmacy and palliative care when possible. o Involve trained, enhanced IHSS workers when possible. o Develop standardized protocols for referral to and coordination with community behavioral health and social services (e.g., visiting nurses, home care services, housing, food, clothing and social support). Identify and train personnel to function as care navigators for carrying out these functions.
Applicable	**2.2.5** Inpatient and outpatient teams will collaboratively develop standardized transition workflows: • Develop mechanisms to support patients in establishing primary care for those without prior primary care affiliation. Develop process for warm hand-off from hospital to outpatient provider, including assignment of responsibility for follow-up of labs or studies still pending at the time of discharge.
Applicable	**2.2.6** Develop standardized workflows for post-discharge (outpatient) care: • Deliver timely access to primary and/or specialty care following a hospitalization. • Standardize post-hospital visits and include outpatient medication reconciliation.

Check, if applicable	Description of Core Components
Applicable	**2.2.7** Support patients and family caregivers in becoming more comfortable, competent and confident in self-management skills required after an acute hospitalization by providing: • Engagement of patients in the care planning process. • Pre-discharge patient and caregiver education and coaching. • Written transition care plan for patient and caregiver. • Timely communication and coordination with receiving practitioner. Community-based support for the patient and caregiver post hospitalization focusing on self-care requirements and follow-up care with primary and specialty care providers.
Not Applicable	**2.2.8** Engage with local health plans to develop transition of care protocols that ensure: coordination of care across physical health, substance use disorder and mental health spectrum will be supported; identification of and follow-up engagement with PCP is established; covered services including durable medical equipment (DME) will be readily available; and, a payment strategy for the transition of care services is in place.
Not Applicable	**2.2.9** Demonstrate engagement of patients in the design and implementation of the project.
Not Applicable	**2.2.10** Increase multidisciplinary team 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 care model.
Not Applicable	**2.2.11** Implement a system for continual performance feedback and rapid cycle improvement that uses standard process improvement methodology and that includes patients, front line staff and senior leadership.

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

Rationale:

The local chronic disease burden is significant, as are social determinants that contribute to poor health outcomes. With no managed care in effect, patients tend to "doctor-hop", rather than engaging with a single primary care provider.

A patient-centered Care Management program will establish long-term healing relationships between provider and patient to assure continuity of care, mitigate adverse outcomes by identifying and resolving barriers to care, and engage patients in healthcare decisions.

Implementation Plan:

PVHD will implement a clinic-based Complex Care Management Program to address medical, behavioral, and socioeconomic challenges that increase the likelihood of adverse outcomes. The clinic-based RN Care Coordinator will work with designated populations to improve quality of life while reducing costly ED visits and hospitalizations. The RN Care Coordinator will work with the hospital-based RN Care Manager to support seamless transitions of care, and also link to the Behavioral Health program, ensuring that persons with chronic conditions receive behavioral change support for self-care. Through this PRIME project, PVHD intends to:

- Establish inclusion criteria for the target population (diagnosis, utilization, referral, etc).
- Develop a tiered approach to care management so that intensity and frequency of services is matched with patient need.
- Deploy patient-centered care management methodologies to engage patients in health goal-setting and enhance confidence in self-care
- Collaborate with community providers to improve access to specialty services
- Implement evidence-based protocols for diabetes, COPD and CHF management
- Design and implement protocols for wound care, including home health services
- Become a provider in California's Comprehensive Perinatal Services Program (CPSP) for at-risk prenatal patients
- Refer all patients identified with a behavioral health issue to PVHD's new Behavioral Health Program
- Share performance metrics with internal and external stakeholders to monitor program effectiveness, raise awareness of quality of care, provide a platform for quality improvement

1. *Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]* *137*

Target Population: With an understanding of the chronic disease burden in the PVHD service area, the target population will include persons with congestive heart failure, COPD and diabetes. Additionally, persons with intractable wounds and will receive care

management services. Pregnant women enrolled in the CPSP program will also receive care management.

Vision for Care Delivery. The PRIME initiative will enable PVHD to develop the infrastructure and protocols for a patient-centered care management program. This will improve our ability to support patients with chronic conditions who could be at risk for unnecessary ED use or avoidable readmissions in the absence of care management support. Our new system of care will establish and reinforce long-term relationships with our patients will provide efficiency at the clinic level; continuity and confidence at the patient level. Investments in the care management staff, behavioral health team, perinatal services, and EHR technology, as well as collaborative planning with the community, will help PVHD improve access to care, facilitate efforts in care coordination, and ensure utilization of the right healthcare resource at the right time.

3. *Infrastructure-building Process Measures* - Yes, see Appendix 2.

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

Check, if applicable	Description of Core Components
Applicable	**2.3.1** Develop a complex care management program at one site or with one defined cohort, or expand an existing program from a pilot site to all sites or to additional high-risk groups and demonstrate engagement of patients in the design and implementation of the project.
Applicable	**2.3.2** Utilize at least one nationally recognized complex care management program methodology.
Applicable	**2.3.3** Identify target population(s) and develop program inclusion criteria based on quantitative and qualitative data (e.g., acute care utilization, lack of primary care utilization, number of high-risk medical mental or SUD conditions, polypharmacy, primary care input, functional status, patient activation, social support or other factors). Include patient factors associated with a higher probability of being impacted by complex care management.
Not Applicable	**2.3.4** Conduct a qualitative assessment of high-risk, high-utilizing patients.
Applicable	**2.3.5** Establish data analytics systems using clinical data sources (e.g., EHR, registries), utilization and other available data (e.g., financial, health plan, zip codes), to enable identification of high-risk/rising risk patients for targeted complex care management interventions, including ability to stratify impact by race, ethnicity and language.
Not	**2.3.6** Develop a multi-disciplinary care team, to which each participant is

Check, if applicable	Description of Core Components
Applicable	assigned, that is tailored to the target population and whose interventions are tiered according to patient level of risk.
Applicable	**2.3.7** Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets.
Applicable	**2.3.8** Implement evidence-based practice guidelines to address risk factor reduction (smoking cessation/immunization/substance abuse identification and referral to treatment/depression and other behavioral health screening, etc.) as well as to ensure appropriate management of chronic diseases: • Use standardized patient assessment and evaluation tools (may be developed locally, or adopted/adapted from nationally recognized sources). Use educational materials that are consistent with cultural, linguistic and health literacy needs of the target population.
Applicable	**2.3.9** Ensure systems and culturally appropriate team members (e.g. community health worker, health navigator or promotora) are in place to support system navigation and provide patient linkage to appropriate physical health, mental health, SUD and social services. Ensure follow-up and retention in care to those services, which are under DPH/DMPH authority, and promote adherence to medications.
Applicable	**2.3.10** Implement technology-enabled data systems to support patients and care teams throughout the care management program including patient identification, pre-visit planning, point-of-care delivery, care plan development and population/panel management activities.
Applicable	**2.3.11** Implement a data-driven system for rapid cycle improvement and performance feedback to address quality and safety of patient care, which includes patients, front line staff and senior leadership.

Please complete the summary chart:

	For DPHs	For DMPHs
Domain 2 Subtotal # of DPH-Required Projects:	**3**	**0**
Domain 2 Subtotal # of Optional Projects (Select At Least 1):		**2**
Domain 2 Total # of Projects:		**2**

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 $ 3,500,000
- DY 12 $ 3,500,000
- DY 13 $ 3,500,000
- DY 14 $ 3,150,000
- DY 15 $ 2,677,500

Total 5-year prime plan incentive amount: $ 16,327,500

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 1: References

1. California Healthcare Almanac, California Health Care Foundation, April 2015
2. Ibid.
3. Health Services Advisory Group (HSAG) report, Q22015—Q12015
4. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2011-12
5. California Healthcare Almanac, California Health Care Foundation, April 2015
6. Community Health Profile 2013, Riverside County, Department of Public Health
7. UCLA California Health Interview Survey, 2011-2012
8. County Health Rankings, 2014
9. Ibid.
10. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2011-12
11. Community Health Profile 2013, Riverside County, Department of Public Health
12. Community Health Profile 2013, Riverside County, Department of Public Health
13. Ibid.
14. US Census Bureau, American Community Survey, 2009-2013
15. US Census Bureau, Small Area Health Insurance Estimates, 2013
16. US Census Bureau, American Community Survey, 2009-2013
17. US Census Bureau, Decennial Census, 2010
18. US Census Bureau, American Community Survey, 2009-2013
19. Ibid.
20. Ibid.
21. Ibid.
22. Ibid.
23. US Department of Labor Bureau of labor Statistics, July 2015
24. US Census Bureau, American Community Survey, 2009-2013
25. Ibid.
26. Ibid.
27. US Census Bureau, American Community Survey, 2009-2013
28. Health Services Advisory Group (HSAG) report, Q22015—Q12015
29. Ibid.

Appendix 2: Infrastructure Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
1.	Conduct training for staff on patient-centered medical home model, including care management and care coordination best practices	• Initial TCPI training completed • Additional training needs identified and documented	1.1 2.2 2.3	July 2016 – July 2017
2.	Design and implement EHR system enhancements to support clinical documentation and quality reporting	• Analyze functionality in new Allscripts EHR system and work with vendor to: o enable data capture and reporting for PRIME projects o ensure clinical documentation templates are user friendly and contain appropri	1.1 2.2 2.3	July 2016- July 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		ate content for behavioral health, condition-specific care management, and care transitions • Understand the reporting capabilities of Lightbeam in the context of PRIME reporting • Train staff on new EHR system		
3.	Implement clinical workflows to support PRIME projects in behavioral health and care management	• • Current workflows evaluated and modified as needed • Staff trained on new workflows	1.1 2.2 2.3	July 2016- July 2017
4.	Develop and implement Behavioral Health	• BH Integration Workgroup convened	1.1	July 2016- July 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
	integration plan	• Evidence-based best practices in BH integration researched and incorporated into integration plan • Standardized BH screening tools researched and adopted • Referral criteria and processes defined • Curricula developed for staff training • Staff training completed		
5.	Improve specialty referral resources in the local community	• Existing referral resources inventoried and analyzed for gaps • Outreach plan developed, to include potential	1.1 2.2 2.3	July 2016- July 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		partnerships with out-of-area health systems, i.e. Loma Linda Medical Center • Outreach to specialists completed • Specialty care partnerships formalized through business agreements and/or contracts • Feasibility study for telehealth completed • Referral protocols formalized through collaboration with specialist and PVH medical director, to include specialist's criteria for primary care service completion prior to		

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		referral appointment • Regular updates provided to PVHD providers re: new specialty referral options in the local community • Closed loop referral tracking implemented • Staff training on referral tracking protocol completed • Referral tracking to include specialty appointments completed locally vs those requiring long distance transportation		
6.	Improve access to primary care through	• Physical space planning/	2.2 2.3	July 2016- July 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
	expansion of existing clinic from 2 to 5 exam rooms	layout completed • Primary care provider hired • Support staff hired • Number of available appointments increased by 50% • Time lapse from day of appointment request to day of appointment reduced by 50% • Patient visits/encounters increased by 50%		
7.	Expand Palo Verde Hospital outpatient services to support primary care, care management and post-acute care transitions. New services to include: • Home Health • Wound	• Completed business plan (including staffing, space, technology, revenue projections, etc) • Completed implementation strategy for new	2.2	July 2016-July 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
	Care • Perinatal Care	services. • Referral protocols developed for each service. • Cost center and billing criteria for each service established • EHR functionality evaluated and updated as needed to support clinical documentation and data capture for the new service areas, including the use of mobile devices for home health personnel • Certification as CA CPSP Provider completed • CPSP training completed • Wound care		

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		treatment training completed		

Appendix 3. PVH Overview of Strategic Goals 2016-2018

Items in red denote alignment with PRIME Initiative

Palo Verde Hospital
Overview of Strategic
Goals 2016-2018

Strategic Goal	2016				2017				2018			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Ongoing compliance with regulatory/accrediting agency standards.	x	x										
Successful CDHP Patient Safety/MERP Licensing Survey		x										
Complete Implementation of ISO Standards for Compliance						x						
Full Implementation of Children's Diabetic Program					x							
Swing Bed Licensure		x										
Reduce AMAs/Elopements/Waiting Times in ED		x										
Upgrade ED from Standby to Basic [CDHP]				x								
Clinical/Financial Conversion from HMS to Allscripts		x										
Educate Staff/Incident Command System/disaster response				x								
Obtain DNV Certification in Infection Control					x							
Obtain funding for new mammography unit			x									
Post-Acute-Care Transition Programs through Clinic												
Integrated Medical-Behavioral Health Program			x									
340 B Pharmacy Program				x								
Comprehensive Perinatal Outreach Program				x								
Home Health Outreach Program					x							
Hyperbaric-Wound Management Program					x							
Outpatient Dialysis Services						x						
Outpatient Respiratory Rehab Program			x									
Written and Detailed Succession Planning Program					x							
Pay for Performance Program			x									

Develop a working Partnership with the Practice Transformation Network through Rural Health Consortium	x											
Implement new value-based payment models			x									
Implement Nurse-Advice Hotline				x								
Implement data analytics				x								
Initiate “real-time” value-based satisfaction surveys				x								

Appendix 4. Population Health Management Approach