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**

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

SENECA 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]*
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 community.

Seneca Healthcare District (SHD) is a critical access hospital, providing comprehensive health care in the Lake Almanor area of Plumas County through a hospital, standby emergency department (ED), skilled nursing facility, and hospital based rural health clinic. The health care needs and disparities of our community are summarized below as reported in the 2007 Plumas County Community Health Profile, 2013 DHCS County Health Profile and OSHPD Data.

Behavioral Health: Access to behavioral health in our service area is limited due to a lack of providers and services available in Plumas County. In the SHD service area there are no behavioral health services available outside of the primary care providers. The suicide rate for Plumas County was 18.4% in 2007 and rose to 22.2% in 2013.

The Plumas County Mental Health Department estimates that 23% of the county residents are in need of mental health services. This rate increases as the incomes dip below the federal poverty level (FPL). In addition, the rate of Plumas County adolescents who report routine use of drugs or alcohol is at a high of 36% versus a California rate of 27% per the California Healthy Kids survey.

Physical Health: The prioritized health issues for our community have been listed as Congestive Heart Failure, Chronic Obstructive Pulmonary Disease , and Asthma. The Mortality rate for heart disease per 100,000 population in Plumas County is 73.6%, while the mortality rate for lung and respiratory cancers per 100,000 population is 42%. The adjusted rate for asthma related ED visits in Plumas County is 57 visits in the ED per 100,000 with the state rate of 48 ED visits per 100,000.

Health Disparities: Plumas County residents have poor health outcomes and experience a fragmented continuum of health care. Poor health outcomes are directly related to the inappropriate use and lack of access to health care services, and to the numbers of uninsured, underinsured, and those eligible but not enrolled in public benefit programs. Income levels account for some of the disparities as

11% of the SHD service area is at 100% of the FPL, while 22% are at 200% of the FPL. Only 58% of the population in the service area has job-based or other health coverage year round. Approximately 25% of the patients visiting the ED are without private or public insurance. We are hoping to utilize the opportunity to participate in PRIME to address the full range of issues outlined above.

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

Seneca Healthcare District is located in Chester, CA in Northern Plumas County, within the Lake Almanor area. The service area includes10 people per square mile or an estimated population of 3,062 per the 2013 OSHPD data.

Income: The median family income for the service area is $31,739 and the estimated per capita income is $22,215 per 2013 census bureau statistics. These income levels make 11% of the SHD service area living at or below the poverty level, while 22% are at 200% of the FPL. The median housing cost is $ 275,000.

Race/Ethnicity and Language: The population of the SHD is 92% Caucasian, 4% American Indian, 1% Hispanic and 3% other. The primary language spoken is English, with very few other dialects spoken. Eighty eight percent (88%) of the community have a high school education or higher.

Age: The population is slightly high in the 65 and older population than the state (39.7%) with the median age of 49.1 years.

The age breakdown is:	under 18yrs old – 16%	State – 25%
	10-64 years – 54%	State – 63.1%
	65 years and older – 29%	State – 11.4%

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.

SHD is a Critical Access Hospital with 10 inpatient/swing beds, 16 bed distinct part skilled nursing facility and a hospital based rural health clinic. Our emergency department has a standby, level IV trauma designation. We provide inpatient and outpatient surgical services, respiratory care, physical therapy, a wide variety of diagnostic laboratory services and imaging services including ultrasound, mammography, dexa-scan, CT and a portable MRI unit. Our walk-in clinic is open 6 days a week, Monday – Saturday, 8 hours a day. Our RHC has 3 full-time family practice physician providers, 1 family nurse practitioner, and part time specialists

covering podiatry, orthopedics, family practice/OB, and dietitian. We currently have a locum practitioner who is filling in over the summer during our summer season when volumes increase.

Our payer mix mirrors our population age range. In FY 2015 SHD experienced a mix of Medicare – 40.3%, Medi-Cal – 25.2%, Blue Cross/Blue Shield – 23%, Commercial – 7.7%, Worker's compensation – 1.2% and self-pay – 2.7%.

For FY 2013, our average length of stay for acute care was 3.17 days. Our Acute hospital beds had an occupancy rate of 17.26% with an average daily census of 1.73. Our DP/SNF had an average daily census of 14.78 with an occupancy rate of 94.59. We had 93 acute inpatient discharges, 1,793 emergency visits, 219 surgical procedures and 7,963 clinic visits.

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.

Recently, SHD has reorganized the Quality Management (QM) Program. Our current QM/Care Coordinator has long-term ties to the community and plans to remain in her current role. Our most significant barrier to meeting the PRIME reporting requirements is our limited staff available for our quality team. The CNO and CEO both have experience in the quality/care coordination and serve as a mentor/backup for the QM/Care Coordinator.

Implementation: The QM/Care Coordinator reporting to the CNO, shall have the primary responsibility and lead the PRIME Project through the QM Program with the assistance from the Clinic manager, Department managers and staff of the areas involved. The CNO has administrative oversight of the PRIME Project.

Data Collection: Our QM/Care Coordinator has re-organized the existing data collection process by streamlining the metrics into a user-friendly format enabling the collecting of data in a more systematic fashion, thereby reducing duplicate metrics collected by different disciplines. The PRIME reporting requirements will be integrated into the QM program. The current metrics being collected will include the PRIME Project reporting requirements; all are compatible with our strategic goals and performance improvement indicators.

Reporting: SHD utilizes a wide variety of reporting visuals to report the metrics and the outcomes, including the PRIME reporting requirements. They are posted

throughout the facility keeping the outcomes and targets visible to all. The Interdisciplinary QM Committee meets monthly, reporting their findings to the Medical Staff and quarterly to the Hospital Board, all are in full support of the QM Program.

Monitoring: Our quality information is collected, reviewed and distributed in a systematic manner to ensure all stakeholders are aware of the results. We have established a method to address outliers for further review and correction through the QM Program, allowing for development of strategies to improve the targeted areas of concern as needed.

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.*

   SHD's long range goal is to provide a more streamlined patient centered access to care in the appropriate setting. We aim to improve the health of our community by providing culturally competent, evidence-based, patient/family centered care. Through the PRIME program we intend to implement and maintain a more effective approach to guide our community, patient and family through the continuum of care, avoiding inappropriate use of resources by focusing on improved care coordination and transition of care through the various health care entry points. The PRIME Program administrative oversight will be the responsibility of the CNO. The QM/Care Coordinator has overall accountability with the ED Manager, Clinic Manager and Providers will play an integral part in the success of the program.

Our long term goal is to support a care delivery model at SHD that will be better able to accommodate the concept of the patient-family in the various care settings that will be appropriate for the patient's clinical, behavioral and social needs.

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.*

   SHD has two specific aims that interconnect with our PRIME participation: to improve access to behavioral health care services by better identification, and providing access to the appropriate health care service/entry point through enhanced communication and availability with a care coordination model.

   The need for behavioral health services will be consistently identified through the Care Coordination process in the inpatient and outpatient/clinic settings. This will enable SHD providers to identify the behavioral health needs and link the patient/family with the resources available within the community and in the outlying areas. The QM/Care Coordinator and Clinic Manager will be able to drive the appropriate access to healthcare services by facilitating as a guide to healthcare and behavioral health needs. The additional accountability for the success of the implementation and ongoing compliance of these programs, including the PRIME Project is with individual department managers of the areas involved. This will be accomplished through a strengthened standardized referral process by improving referral relationships, enhancing telehealth capabilities and consistent follow up through care coordination.

   Through our care coordination program, we will be able to standardize the district's health care delivery services, in various care settings, ensure adequate staffing based on appropriate patient/case ratios, and reduce avoidable readmissions and access to inappropriate service entry points. This shall be accomplished through standardized procedures that will enhance discharge planning, improve the medication management and reconciliation process, improve post-acute and ED follow-up calls and open communication between the care delivery service areas.

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;

SHD selected PRIME project 2.2 Care Transitions: Integration of Post-Acute Care. This project directly correlates with our community needs assessment regarding access to care in the appropriate setting and the lack of identification and resources for behavioral health in our community. We will be able to enhance our care coordination by developing a more complex care coordination model that spans the entire healthcare services for the district.

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

   N/A

5. *Provide a succinct summary description of how your hospital or health system will be transformed at the end of the five years. Explain how this transformation should result in advances in clinical, population health, fiscal or other critical outcomes through PRIME.*

   After five years, patients/families served by SHD shall receive the correct clinical and support services, with easy access, and in the appropriate care setting for their health care needs. There will be an infrastructure and staff to support and identify acute and chronic physical and behavioral health care needs and through the care coordination program will provide continuous and seamless access to the services across the district.

   By the use of care coordination program we anticipate decreasing avoidable readmissions, unnecessary use of the ED and supporting the patient/family centered model to keep our community healthier. Providing better access and utilization of appropriate health care services will also improve our reimbursement, allowing us to remain in the business of providing health care services to the community.

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.

After reviewing the data as submitted in Section 2.1, attention is drawn to our focus of behavioral health and patient/family centered care coordination program. By

providing an enhanced care coordination model that focuses on the health of the patient/family through follow-up phone calls, medication management and walking patients/family through the appropriate care delivery setting we will be providing the community with better access to health care thus making a healthier community. SHD believes that this care coordination program will provide the community with the support needed to decrease the amount of substance abuse and behavioral health disorders that are left unidentified and not treated.

Improving the organization of the care coordination program will also improve the delivery of our various health care services that addresses the needs of the health care in the community with the expectation of improving both physical and behavioral health outcomes, as well as the patient experience with the health care system. We also anticipate a more favorable use of the inpatient; outpatient and ED health care services as patients/families are better able to manage their care while accessing additional resources within the community. The end goal is providing access to care to improve the health of the community.

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).

SHD's strategic plan focuses on providing excellent health care services to the community we serve. As a district hospital our board members are elected public officials and serve the taxpayers of our district. Our Board members are very knowledgeable regarding the need to provide appropriate health care services to the community, access to health care and the need to reduce inappropriate utilization of the services. They are committed stakeholders and are actively engaged in oversight of the quality improvement and PRIME-related activities of our district.

The organizational goals and strategic plan align with the PRIME Project requirements by changing the responsibilities and duties of the QM/Care Coordinator role. The QM/Care Coordinator has the accountability to integrate the philosophy of the right patient in the right care setting, at the right time, which is part of our organizational goals and strategic plan into the Care Coordination Program.

At the end of 2015, SHD reorganized the QM Program to include all quality/performance improvement activities within the district to report to a facility wide quality committee. This committee has now included the PRIME project as an ongoing monthly agenda item, allowing for a more focused oversight of the PRIME

project at all levels of administrative, medical and governance on a monthly and quarterly basis. Restructuring the QM/Care Coordinator role begins the change in the organizational structure and strategic plan to provide the community the resources to access the appropriate healthcare services in the appropriate setting.

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.

SHD will ensure that stakeholders and beneficiaries have multiple opportunities to be engaged in PRIME Project planning and implementation. This shall be achieved through existing access points of participation. The Quality Management committee is made up of stakeholders and the reporting structure is such that line staff, medical staff and governance have input in the meetings. The patients/families have access to input through the customer satisfaction survey, interviews with the care coordinator and CNO, SHD hosted Community Forums and at the public comment period during the District Board meetings.

SHD will continue to host Community Forums to allow the opportunity for engagement and input of beneficiaries during the planning, implementation and review of the QM Program, There will be specific questions posed to encourage open communication and participation of those involved in the planning and implementation activities. SHD has also improved upon our relationships with the community based organizations that provide support services to our patients, county and community. We will continue to work with these stakeholders as part of the QM Program which includes PRIME planning and implementation and will identify additional organizations that may add valuable input to the PRIME activities.

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

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

SHD has a track record of implementing approaches to meet the needs of our diverse population. This includes working to ensure providers and staff reflect the diversity of our patients and that all of our patients/families have access to health information in a language and reading level of choice and competency. We intend to continue to provide activities and services as part of our commitment to provide culturally and age competent service and care.

In order to support these efforts we will continue to translate educational materials into our identified languages with real-time access to interpreters as needed. Also we will be ensuring that all educational materials are printed at a reading level consistent with our population. We also intend to continue with our health fairs that are focused on wellness in the community. These health fairs have material and information that are targeted to our diverse age and cultural population. We feel that this will assist in closing the gap to our community cultural, age and health disparities.

3.6 Sustainability. [No more than 150 words]

Provide a high-level description of the systematic approach for quality improvement and change management that your organization plans to use. The narrative should describe the specific components you have in place, or will implement as part of PRIME, which will enable you to sustain improvements after PRIME participation has ended.

SHD has participated in many quality/performance improvement learning collaboratives, seminars, and events, including reduction of infections, and improving patient experience satisfaction, prevention of readmissions within 30 days and implementing the patient centered care model, as an example of content. The outcome of this work has been the ability to network with peers to assist in improving our quality management program, ultimately improving patient outcomes. We feel as a result of these efforts we will be able to leverage this experience to sustain not only the PRIME improvement, but other quality metrics as well. Examples of how this will be sustained and achieved; by engaging providers and staff in the planning and implementation process, provide focused, varied training and educational opportunities to improve the knowledge base and develop learning opportunities to fill the gaps in education, ensure high-level support for the quality management and PRIME implementation by relying on proven methods.

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]*

   SHD selected this PRIME project as it directly correlates with our community needs assessment regarding access to care in the appropriate setting and the lack of identification and resources for behavioral health in our community. We will be able to enhance our care coordination model by developing a better, more complex care coordination model that spans the entire care delivery services for the district.

   The approach for implementation starts with the Quality Management Program, which includes the care coordination process. We will be expanding the existing program to include a nationally recognized care transitions program. We will be developing a consistent system to track, report, improve and redesign for positive outcomes on the care transition metrics determined. Implementing a

care coordination/transition team that involves both the inpatient and outpatient settings is essential. This team will develop and implement mechanisms to streamline the inpatient discharge, post-acute care and outpatient services to deliver an improved understanding and access to appropriate health care entry points.

The quality management program will be redesigned to include the PRIME project and metrics into the monitoring and reporting structure with the ultimate goal of improved patient /family care and satisfaction. This includes reporting outcomes at various levels in the organization including medical staff and hospital board meetings. We aim to improve the health of our community by providing culturally competent, evidence-based, patient/family centered care. Through the PRIME program we intend to implement and maintain a more effective approach to guide our community, patient and family through the continuum of care, avoiding inappropriate use of resources by focusing on improved care coordination and transition of care through the various health care entry points.

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

The patients/families served by SHD shall receive the correct clinical and support services, with easy access, and in the appropriate care setting for their health care needs. There will be an infrastructure and staff put into place to support and identify acute and chronic physical and behavioral health care needs. Through the care coordination program SHD will provide continuous and seamless access to the appropriate healthcare service entry points across the district. By the use of the care coordination program we anticipate decreasing avoidable readmissions, unnecessary use of the ED and supporting the patient/family centered model to keep our community healthier. Providing better access and utilization of appropriate health care services will also improve our reimbursement, allowing us to remain in the business of providing health care services to the community.

Improving the organization of the care coordination program we will also improve the delivery of our various health care services that addresses the needs of the health care in the community with the expectation of improving both physical and behavioral health outcomes, as well as the patient experience with the health care system. We also anticipate a more favorable use of the inpatient; outpatient and ED health care services as patients/families are better able to manage their care while accessing additional resources within

the community. The end goal is providing access to care to improve the health of the community.

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.*

SHD selected PRIME project 2.2 Care Transitions: Integration of Post-Acute Care which will need a redesign of infrastructure-building 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.*

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

SHD selected this PRIME project as it directly correlates with our community needs assessment regarding access to healthcare in the appropriate setting and the lack of identification and resources for behavioral health in our community. We will be able to enhance our care coordination model by spanning the entire healthcare delivery services for the district.

Implementation starts with the QM Program, including the care coordination process. Our current QM/Care Coordinator is a “home grown” resident, committed to the quality role and will bring stability and consistency to the QM Program. The CNO and CEO have experience in the quality and care coordination areas. By the 3rd quarter, the existing program will include a nationally recognized care transitions program targeting the inpatient and outpatient settings. This will provide a consistent system to track, report, improve

and redesign for positive outcomes on the care transition metrics. The model will be a template to streamline the inpatient discharge, post-acute care and outpatient services to deliver an improved understanding and access to appropriate health care entry points.

The QM Program will be redesigned to include the PRIME Project requirements with the ultimate goal of improved delivery of healthcare. Outcomes will be reported at various levels in the organization including community forums, medical staff and hospital board meetings. We aim to improve the health of our community by providing culturally competent, evidence-based, patient/family centered care. Through the PRIME program we intend to implement and maintain a more effective approach to guide our community, patient and family through the continuum of care, avoiding inappropriate use of resources by focusing on improved care coordination and transition of care through the various health care entry points. The goal is to have the PRIME Project requirements integrated into the QM Program and reported to the Hospital Board by the end of the year.

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

The patients/families served by SHD shall receive the correct clinical and support services, with easy access, in the appropriate care setting for their health care needs. We will be targeting the inpatient population to ensure care coordination continues post discharge through an enhanced discharge care plan education. The staff will provide follow-up care and communication utilizing a combination of methods to provide continuous and seamless access to the appropriate healthcare service entry points. The existing infrastructure and staff will be enhanced to support and identify acute and chronic physical and behavioral healthcare needs of the community. By the use of the care coordination program we anticipate decreasing avoidable readmissions, unnecessary use of the ED and supporting the patient/family centered model to keep our community healthier. Providing access and utilization of appropriate healthcare services will also improve our reimbursement, allowing us to remain in the business of providing healthcare services to the community.

By improving the organization of the care coordination program we will improve the delivery of our various healthcare services that addresses the needs of the healthcare in the community with the expectation of improving both physical and behavioral health outcomes, as well as the patient experience with the healthcare system. We anticipate a more favorable use of the inpatient; outpatient and ED healthcare services as patients/families are better able to

manage their care while accessing additional resources within the community. The end goal is providing access to care to improve the health of the community.

5. ***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.*

   SHD selected PRIME project 2.2 Care Transitions: Integration of Post-Acute Care which will need a redesign of infrastructure-building 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.*

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.
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.

Check, if applicable	Description of Core Components
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.
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.

Check, if applicable	Description of Core Components
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.
Applicable	**2.2.9** Demonstrate engagement of patients in the design and implementation of the project.
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.
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.

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):		**1**
Domain 2 Total # of Projects:		**1**

Section 5: Project Metrics and Reporting Requirements

Each project includes a required set of metrics, as specified in Attachment Q: PRIME Project and Metrics Protocol. All of the metrics for the required and selected projects must be reported each demonstration year (DY) in compliance with Attachment Q.

Participating entities must report and include baseline data for all relevant project metrics and will identify data sources, consolidating data from multiple inpatient and ambulatory systems, and including data on assigned lives reported from health plans reporting on this data semi-annually. Report submissions must include the numerator and denominator data for each of the metrics for which the entity is seeking payment under PRIME. A PRIME participating entity may provide estimates or reasonable projections if particular data is unavailable due to circumstances beyond the PRIME entity's control, including data that is collected and maintained by an external entity, such as an MCP, which has not been provided to the participating PRIME entity in a timely and accurate manner.

DPHs are required to strengthen data and information sharing with MCPs under the PRIME. To support this requirement, DHCS will establish data and information sharing guidelines and/or mechanisms, which DPHs and DMPHs must follow, consistent with applicable state and federal data privacy and security law, to provide for timely sharing of beneficiary data, assessment, and treatment information, for purposes of identifying and treating the beneficiary for PRIME and Whole-Person Care (WPC). DPHs must demonstrate establishment of new and/or strengthened data and information sharing with MCPs during the demonstration. In particular, the following must occur: reporting of complete, accurate, reasonable and timely reporting of encounter data; sharing of treatment and assessment data for care coordination purposes; and, establishment of processes and infrastructure to support MCP achievement of quality improvement efforts when aligned with PRIME projects.

☒ I understand and accept the responsibilities and requirements for reporting on all metrics for required and selected projects

Section 6: Data Integrity

Each PRIME participating entity must establish and adhere to a data integrity policy throughout the execution of the PRIME Program. Participating entities must be able to verify that all fiscal, clinical, and quality improvement work for which a metric claim is reported. State and federal officials reserve the right to require additional substantiation or verification of any data claim or related documentation and may conduct periodic audits when indicated.

☒ I understand and accept the responsibilities and requirements for establishing and adhering to a data integrity policy.

Section 7: Learning Collaborative Participation

All PRIME participating entities are encouraged to actively participate in learning collaboratives that will be launched by DHCS or their designees for purposes of providing technical assistance and information exchange opportunities as PRIME implementation gets underway. At a minimum, each PRIME participating entity is required to participate in at least one face-to-face statewide learning collaborative per PRIME year. Please acknowledge your understanding and acceptance of this responsibility below.

☒ I understand and accept the responsibility to participate in-person at the annual statewide collaborative.

Section 8: Program Incentive Payment Amount

Please indicate the total computable PRIME incentive payment amount for this 5-year plan, consistent with the PRIME Funding and Mechanics Attachment:

Total computable 5-year PRIME plan incentive payment amount for:

- DY 11 $ 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.	Redesign the Quality Management Program to include the PRIME metrics and include a care transition/coordination model.	• Assess current resources • Update Policies and procedures to address changes in the quality management program • Review literature to determine evidenced –based performance measures to demonstrate data driven outcomes • Educate stakeholders in the Care Coordination model	2.2	April 2016 – June 2016
2.	Development of a standardized Care Plan that includes the care coordination model.	• Establish a workgroup to review literature and determine which care transition model to implement. • Develop a draft Care Plan • Work with the Clinical informatics team to integrate the Care Plan into the EHR • Provide education to staff regarding the changes to the Care Plan • Pilot the Care Plan • Redesign the Care Plan after pilot, if needed • Implement the Care Plan	2.2	April 2016-October 2016
3.	Development and	• Revise current Care	2.2	May 2016 –

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
	Deployment of clinical and staff education modules on care coordination.	Coordination and licensed nursing staff job descriptions to include the care coordination duties and responsibilities • Educate the new to her role care coordinator through seminars, conferences and training • Develop curricula modules • Schedule ad conduct trainings • Assess effectiveness of training		December 2016