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**

Sonoma Valley Hospital

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General Instructions

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

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

Scoring

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

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

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

Section 1: PRIME Participating Entity Information

Health Care System/Hospital Name

Sonoma Valley Healthcare District, dba Sonoma Valley Hospital

Health Care System Designation (DPH or DMPH)

DMPH

Section 2: Organizational and Community Landscape

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

2.1 Community Background. *[No more than 400 words]*
Drawing on available data (e.g., DHCS, Office of Statewide Health Planning and Development, U.S. Census Bureau), summarize the health care needs and disparities that affect the health of your local community.

Sonoma Valley Healthcare District incorporates Sonoma Valley and the City of Sonoma and includes a population of 42,000. Within the County of Sonoma there are 108,000 enrollees in Medi-Cal Managed Care and an estimated 8-10,000 live within the healthcare district.

Physical Health: Based on the 2014 OSHPD data the most significant health issues facing our community include:

- Cardiovascular Disease: 53% of Hispanics over the age of 65 in Sonoma County do not take medication for their hypertension and are at risk for chronic comorbid conditions such as CHF and Stroke.
- Diabetes Management: 36.5% of Hispanics over the age of 65 in Sonoma County have management issues with their diabetes which place them at risk for infection, cardiovascular and other chronic conditions.
- Obesity/Overweight: 39.4% of adults in Sonoma County are overweight with a BMI of 25-29 and 21.1% of adults exceed a BMI of 21.2. Being overweight increases the risk of developing Metabolic Syndrome and the development of chronic disease.
- Infections due to Sepsis: Our admissions for infections due to Sepsis (14.9%) are higher than in other areas of Sonoma County and the State average of 6.3% and represent the top reason for hospital readmission. In addition, patients admitted at SVH for sepsis (14% Medi-Cal) are also more likely to have a comorbidity of Diabetes Type I or Type II.

Behavioral Health: Based on our 2015 admission data, 3% of all emergency department visits were solely behavioral health visits, however, 85% of those visits did not have a primary care giver recorded either because there was none or due to clerical error. Our inpatient strictly behavioral/ mental health admissions are few. The main reason for both ED and IP admissions are substance abuse; mainly alcohol related.

Health Disparities: Health Disparities in Sonoma County include higher rates of

uncontrolled hypertension, diabetes, obesity among Hispanics in addition to higher rates for both Whites and Hispanics for infections due to sepsis in Sonoma Valley. Income levels contribute to disparities in access to healthcare in a number of ways. Approximately 5% use the SVH emergency department as their source of primary care.

Low income and education level impact health literacy and the ability to navigate the healthcare delivery system. Over 50% of Sonoma Valley Hispanics have not earned a high school diploma as compared to 8% of Whites.

SVH anticipates using this opportunity to participate in PRIME to address the full range of issues outlined above.

2.2 Population Served Description. *[No more than 250 words]*
Summarize the demographic make-up of the population included in your hospital's service area, including information about per capita income, age, race, ethnicity, primary language, etc.

Population**:** Sonoma Valley's population is currently 42,000; with 10,000 actually living in the city of Sonoma.

Age Distribution: The population of the City of Sonoma is slightly older than in Sonoma Valley. The average age of an inpatient at SVH is 75. The approximate age breakdown for Sonoma Valley is as follows:

0-14 years (15.3%)	CA Average (15.6%)
15-44 years (33.2%)	CA Average (41%)
45-64 years (28%)	CA Average (24.9%)
65+ years (24%)	CA Average (14.9%)

Please take note that all Sonoma Valley data is from 2012.

Race/Ethnicity and Language: Approximately 98% of Sonoma Valley community members are either white (74%) of Hispanic/Latino (24%). English is the primary language in our service area followed by Spanish.

Median Income: The median income of Sonoma Valley can be divided into two subsections. In Sonoma Valley, mostly Hispanic, the median income is 49,460 while in the City of Sonoma, mostly White, the median income is 100,000. Combined, the average per capital income is 74,730. 11% of Sonoma Valley residents live at or below the poverty level, live in the Valley and are more likely to be Hispanic.

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.

Sonoma Valley Hospital is a full service general acute care district hospital We provide acute inpatient, outpatient and emergency care as well as diagnostic services. We are a 75-bed facility, (48 acute care beds & 27 distinct part skilled nursing beds) with an outstanding staff of health care professionals located in the heart of the City of Sonoma. The atmosphere of our hospital is like the atmosphere of Sonoma, we are a warm, comfortable, familial place of healing. We are known for our compassionate and professional staff and for our dedication to the needs and expectations of our community.

Our services encompass the whole spectrum of health care needs, and medical treatment extends to all but the most specialized issues. Specialty services also include a Total Joint Program, Surgical Weight Loss, Women's Health, Family Birth Center, Outpatient Rehabilitation, Wound Care, Cancer Support Program, Travel Medicine and Occupational Health. We are here to lead our patients on the path to health – from their first visit with a primary care physician to their final stay in our Skilled Nursing Facility or Home Care.

In fiscal year 2015 our payer mix is 47% Medicare, 19% Medi-Cal, 1.5% Self Pay, 20.6% Commercial, 6% Medicare Managed Care, 3% Workers Compensation, and 3% Capitated.

In calendar year 2015, our Medicare average inpatient length of stay was 3.9 and the average case mix index was 1.45. Staffed beds as a percentage of licensed beds in 2015 was 36.63 (including Skilled Nursing) or 16.25 counting just acute beds.

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.

Over the past few years, Sonoma Valley Hospital has worked to integrate data streams into one reporting system, *MIDAS*, that pulls from all inpatient systems and in 2012 we implemented our Electronic Health System linking the emergency department, surgical services, inpatient services and skilled nursing. A Home Care electronic health record was implemented in 2013 and a Cost Accounting System was added in 2014. In addition, primary care providers, Sonoma Valley Community Health Center, and

Meritage ACO can selectively access health information through linkages and we can send real time patient information with patients as they move to post discharge settings.

Data Collection. SVH has also worked to create statistically meaningful scorecards and to refine and standardized data definitions for more accurate data analytics. We organize our data collection by data source (e.g. clinical claims, authorization, pharmacy, clinical quality outcomes and utilization management), worked to reduce duplication, link data collection either to performance improvement initiatives or strategic goals.

Reporting. Scorecards are then used to track performance and results are reported throughout the organization to stakeholders, for example leadership, medical staff, the Hospital's Board Quality Committee.

Monitoring. The Quality Department reviews data collection processes and outcomes in an ongoing manner. We have a process for identifying outliers and applying statistical process control methodologies to understand process variations and develop targeted improvement strategies.

Barriers. The most significant barrier to meeting the PRIME reporting requirements is our current inability to collect data from sources outside the organization for example. local pharmacies, for use in 30-day medication reconciliation. We have identified a vendor that will provide the linkages needed to allow for data gathering and reporting and as soon as this software is implemented, this barrier will be removed.

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.*

The Mission of SVH is to improve the health of the community and our vision is to guide our community members in their healthcare journey. Strategic priorities for the organization for 2016-2018 include the following.

- Support Sonoma Valley in becoming a healthy community leading population health in three ways: implement health programs for children, providing programs and services that keep healthy people healthy and lead healing for life for community members that are high risk for illness or for complex care management.
- Continue to provide the highest levels of safety and quality health care to SVH patients focusing on high quality outcomes, the patient experience and working to expand our culture of safety;
- Improve the Hospital's financial stability by increasing volumes, implementing operational efficiencies, and develop innovative services to better meet the needs of our community; and
- Anticipate and prepare for continued changes in healthcare regulations and payment models through the development of network partnerships and evaluating current services lines to determine the best model for the organization.

As part of PRIME, SVH will continue to implement best practice strategies for guiding patients and their families through health care transitions including a focus on improved case management and care transitions to reduce avoidable hospitalizations, readmissions, and utilization of emergency department services. This will support delivery system transformation in three ways: (1) improve access and linkages across the continuum of care for providers, community agencies, pharmacies etc.; (2) improve current efforts to provide whole person care in the setting that is best suited to the patient's physical, mental, emotional and spiritual needs; and (3) develop a patient centered collaborative approach where what matters most to the patient in their health and healing journey is central to healthcare decision making.

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.*

SVH has three overarching aims for PRIME participation:

(1) To improve the identification of and access to post discharge transitional care services based on the patient's need for post discharge care.

(2) To expand and standardize how we deliver case management and care coordination services in order to improve discharge planning, consistent medication reconciliation and medication management therapy, post-acute follow-up and care transitions communication over a period of time to reduce readmissions and manage ED utilization.

(3) To develop and standardize a care management program that incorporates the addition of a community health coach for patients needing more complex case management.

SVH anticipates that the development of a standardized case management model targeting clinical and utilization outcomes will improve care delivery and the patient experience for our population.

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;*

SVH selected the Care Transitions: Integration of Post-Acute Care (2.2) project within Domain 2. This directly corresponds to our project aims and will allow us to develop the infrastructure needed to identify and manage care transitions for our at-risk populations while mitigating disparities.

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

Not applicable.

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

At the end of five years, patients served by SVH will receive the right clinical and support services, when they need them, and in the care setting that is optimal for their needs. We will have developed a care coordination system that identifies at-risk populations and the multidisciplinary team, including

community health coaches, to help patients and their families navigate the healthcare delivery system in a more efficient and effective manner. We will have built a communication system among providers and provider agencies that will support an efficient exchange of information. Current quality metrics and the patient experience will show improvement from baseline.

We anticipate a reduction in the cost of care by addressing avoidable admissions, readmissions and unnecessary ED use, and an increased reliance on community –based services, including primary care, to keep people healthier and in their place of residence.

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.

SVH will address the community needs outlined in Section 2.1 by implementing our Care Transitions Project 2.2. By expanding our case management model to the emergency department, we will be able to address our population's need for access to primary care by linking providers to patients, identify community members at risk for physical health concerns including uncontrolled hypertension, heart disease, diabetes and sepsis. It will also result in a strengthening of community members' linkages to mental health services and substance abuse services. In addition, we would build the infrastructure to follow at -risk community members into the community over 30 days through the use of community health coaches. The project will also improve the transition between hospital and home for our inpatient population in order to ensure a clear discharge plan, up to date medication reconciliation, and care transitions oversight through health coaches to prevent readmissions.

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).

Sonoma Valley Hospital's governance strategy is a direct reflection of the hospital's mission, vision and values. As a district hospital, our board members are elected public officials. Board members are very knowledgeable about the health care needs of our community and the need to meet the goals of the Triple Aim.

They are also committed to engaging and supporting the hospital's strategic initiatives regarding population health. Oversight of the PRIME activities will be provided by the Board Quality Committee.

In March 2015, SVH formed the Community Care Network Steering Committee, composed of a multidisciplinary team of hospital and community agency members, to begin planning for PRIME participation. The charter of this committee is to guide the development of the PRIME plan; provide recommendations to Administration and to the Board Quality committee necessary infrastructure investments; and to monitor progress towards SVH's efforts in meeting PRIME goals and performance standards. The Steering Committee met as needed in 2015 and will meet monthly in 2016 during the implementation phase. Updates to the Board Quality Committee from the Chair of the Steering Committee occur monthly.

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.

SVH will provide stakeholders and beneficiaries with multiple opportunities for engagement in PRIME planning and implementation. A consumer representative will have a seat on the Steering Committee and serve as a voting member. We will also provide an opportunity for questions and comment from the public during all Board meetings to ensure that consumers have an opportunity to provide substantive input and feedback into PRIME-related planning.

SVH has existing relationships with a number of community agencies: Sonoma Valley Community Health Center, La Luz and their promodores program, the CERES program that provides healthy nutritional support post –hospital and many of the service area physician/providers are members of our medical staff. We will work to strengthen these relationships and invite feedback and discussion in both the planning and implementation of the project. SVH will also seek out, engage and leverage services from additional community based organizations, such as the County Mental Health department, with the goal of creating a linked network of available services and a standardized process for accessing services. In addition, SVH has reached out to local universities to partner in the development of the role of health coach linking the community health coach role to students pursuing a career in healthcare.

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.

SVH has a history of implementing efforts to ensure that we meet the needs of a diverse population. We attempt to ensure that staff reflect the diversity of our patients, that healthcare information is provided in the language of their choice, that educational information is translated into Spanish and other languages as needed. Wayfinding is provided in Spanish throughout the hospital and we provide real time access to interpreters as needed. When we do community health fairs and existing outreach activities, Spanish speaking staff and providers are involved. Staff also receives trainings related to cultural competence and health disparities. All care transition documents will be in both languages and our partnership with local Hispanic groups in addressing the health care issues in section 2.1 will identify additional resources that will be needed to continue to build cultural competence of our staff.

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.

SVH will leverage its experience with past learning collaboratives to sustain PRIME improvements through the use of the following:

- Engaging leaders, providers and staff in the planning and implementation;
- Providing education and training to close identified gaps in knowledge and skills;
- Ensuring senior leadership support for designing and executing strategies related to PRIME activities; and
- Relying on data driven decision making, including the use of statistical process control, process, outcome and monitoring measures.

The development of the care coordination system, the infrastructure and progress we make in the development and implementation of our PRIME objectives will become the standard for how we manage community members both in the acute and emergency setting after PRIME participation has ended. We anticipate that this is the first step in an ongoing process towards transforming how we provide care to our patients and serve our community.

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 4.2 -- Domain 2: Targeted High-Risk or High-Cost Populations

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

SVH has selected this project because the establishment of a care transitions infrastructure and program is the first step in moving to complex case management. The project will require infrastructure building. Our planned approach is:

- Care Transitions Program: Expand our current care transitions program to include the emergency department case management/social services. We expect to complete this in DY 12
- Medication Reconciliation: Extend efforts at medication reconciliation both in the acute setting and in the outpatient setting such that providers have information about medication history, compliance, and more accurate medication reconciliation through the use of MedMind software . We expect to implement MedMind in DY12 for the hospital & home care and to expand its use to post discharge care providers in DY 13 &14
- Multidisciplinary Care Team: Expand our multidisciplinary team and build standardized workflow processes for the management of patients post hospitalization, whether it be home care, skilled, or via telephone follow-up. We expect to have the process developed in DY 11 and to expand it in DY12
- Linkages Across Care Settings: Build linkages to ensure that patients have access to post hospital services with the local community partners and providers to ensure timeliness of referrals and information exchange. We expect to have new linkages fully developed in DY12.

- Community Health Coaches: Extend Care Transitions model to include the development of Community Health Coaches as part of the care coordination team. Develop a role description, educational standards and a standardized workflow. Develop links with local colleges & community agencies to build a volunteer community health coaching program. We expect to have links established in DY 12, pilot health coaching in DY 12 with full implementation in DY 13.

Target Population: It is our intention to include all patients, discharged after an acute inpatient stay in our target population for the prevention of readmission, medication reconciliation, and post discharge transition planning. In addition, we will be targeting at risk patients in the acute setting presenting with Sepsis. Patients will also be assessed for co-morbid conditions that include uncontrolled hypertension, behavioral health issues or who need assistance with diabetes prevention and management. Screening criteria will also be applied to patients presenting to the Emergency Department in addition to identifying and addressing reasons for over utilization related to lack of access to primary care, behavioral health, housing, insurance and or the inability to navigate the healthcare delivery system.

Vision for Care Delivery: This project will allow us to improve the coordination of care within the acute and emergency department setting and out into the community at the time of discharge. It will also allow us to build the necessary community linkages to facilitate a safer, more patient-centric approach to ensuring the best outcomes for community members. Our program will improve care transitions through several activities: identifying post-acute or post ED discharge needs; connecting patients with community based clinical and non-clinical services; managing medications both in and out of the hospital, providing a community health coach navigation process post discharge to community members most at risk; and creating a system for monitoring progress. Case Managers and community health coaches will also work to engage patients in self-management, support healthy lifestyle choices and the adoption of healthy behaviors, and help patients and families form a life plan around what matters most to them.

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.
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.
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.
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.

X 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.

X 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.

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

Section 8: Program Incentive Payment Amount

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

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

- DY 11 $ 1,500,000.00
- DY 12 $ 1,500,000.00
- DY 13 $ 1,500,000.00
- DY 14 $ 1,350,000.00
- DY 15 $ 1,147,500.00

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

Section 10: Certification

X I hereby certify that all information provided in this Plan is true and accurate to the best of my knowledge, and that this plan has been completed based on a thorough understanding of program participation requirements as specified in Attachment Q and Attachment II of the Waiver STCs.

Appendix- Infrastructure Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
1.	Expand Case Management to the ED	1. Hire and train ED Case Manager 2. Develop a role description and set up a standardized workflow. 3. Develop screening tool for identification of at –risk patients in the ED. 4. Build a documentation database for Community Case Management in our current Midas system. 5. Train the Case Managers and Social worker on how to access and use database.	2.2.1	July 1, 2016 – January 30, 2017
2.	Medication Reconciliation and compliance Tracking 30 days post discharge	1. Install the Care Transitions Module of the MedMind software and test linkages to area outpatient pharmacies. 2. Train physicians and case managers on use of this process in the documentation of home medications and medication reconciliation. 3. Begin reporting of Medication Reconciliation-30 day metric	2.2.4	January 1, 2017 – March 30, 2017
3.	Integration of Health Coaches into Care Transitions Program	1. Develop a role description, workflow process, educational standards for the community health coach role. 2. Train coaches. 3. Pilot project to identify gaps in process. 4. Develop metrics. 5. Full implementation for health coach caseloads	2.2.4	January 1,2017 – June 30, 2017

Appendix- References

AHRQ National Healthcare Quality and Disparities Report: Chartbook on Care Coordination, 2014

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Medi-Cal Managed Care Enrollment Report 2015

OSHPD Racial & Ethnic Disparities in Healthcare in California, Winter 2010

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Sonoma County Quick Facts from the US Census Bureau