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

PALM DRIVE HEALTHCARE DISTRICT

SONOMA WEST MEDICAL CENTER

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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

Palm Drive Healthcare District Sonoma West Medical Center

Health Care System Designation (DPH or DMPH)

DMPH

Section 2: Organizational and Community Landscape

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

2.1 Community Background. *[No more than 400 words]* 380
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 County is a large, urban-rural county encompassing 1,575 square miles in Northern California. The total population is estimated at 487,011.

Physical Health: Coronary Heart disease is the third leading cause of death for people ages 18-59 in Sonoma County. For residents, age 60 and older, coronary heart disease and stroke are the second and third most common cause of death, behind cancer.[1] The CHD death rate was higher for males than females. For 2004-2006 the CHD death rate is higher for White, non-Hispanics than for Hispanics and Asian/Pacific Islanders. Deaths from CHD were disproportionately high for White, non-Hispanics; 93.8% of deaths but 85% of the population >45 years.[2]

Diabetes: Hospitalizations for Diabetes related conditions in 2005-2007 were 46.1% for the age 35-64. The death rate for conditions with "diabetes as a primary or contributing cause of death" is higher for Whites (394.3/100,000) than for Hispanics. [3]

Chronic Lower Respiratory Diseases: CLRD hospitalization rates were higher for females than males. The CLRD hospitalization rate for African Americans is higher than rates for other race/ethnicities. Chronic bronchitis and asthma were the cause of more than 94% of all CLRD hospitalizations.[4]

Behavioral Health/Substance Abuse: Nearly 20% of adults ages 18-59 reported needing help for emotional/mental health problems or alcohol/drug issues. Low income individuals with mental health/substance abuse concerns do not have access to the treatment they need. Insufficient private insurance coverage for mental health services and insufficient availability of publicly funded treatment services are significant barriers for many. Limited integration of mental health services within the health care system leads to missed opportunities for early problem identification and prevention. [5]

Health Disparities:
Hispanic adults in the 18-59 age group have higher obesity rates (38.5%) than Whites (20%).
Adults with incomes below 200% of FPL have higher rates of obesity than adults with incomes above that level (28.0% and 22.6%).

27.2% of Hispanic survey respondents report having had a mammogram within the past 2 years as compared with 59% of White respondents.
The death rates among Whites for each of the leading causes of death (cancer, coronary heart disease, chronic lower respiratory diseases, stroke and Alzheimer's) are more than twice what they are for Hispanics .[6]

Coverage:
Sonoma County Residents have the following healthcare coverage:
61% Commercial/Private insurance
15% Medicare
10% Medi-Cal
14% uninsured

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

Race/Ethnicity/Language.
79% of Sonoma counties' population is white including
Hispanics(26% of the white population), 1.5% African American, 1.2% American Indian, Asian/Pacific Islander (5.2%), African Americans (1.7%), American Indians (1.0%), and persons reporting two or more races (2.3%).
 Languages: 80% of households speak English, 13.8% Spanish, 2.2% Asian/ Pacific, 3.3% other European languages [7]

Age: The median age of Sonoma county residents is 39.50 years. Seniors, age 60 and over, represent 20.4% of the total population compared with a statewide figure of 16.9%.   24.2% of the population is under 17 years. 55.4% of population is ages 18-59. [8]

Social: Of residents 25 years or older, an estimated 87% were high school graduates (includes equivalency) and 34.8% had a bachelor's degree or higher. The unemployment rate in is 7%. The census data also reports that 5.4% of residents did not have a car available to them.[9]   In 2015, 3,107 people were identified as homeless individuals in the County.[10]

Income: From 2006-2010, the median income of Sonoma County's 184,000 households was $63,274. 17.7% of Sonoma County households had incomes of less than $25,000, with 28% of households earning over $100,000 annually. 11% of Sonoma County residents live below the federal poverty guidelines of $10,830 for a single adult, $22,050 for a family of four. In Santa Rosa more than 13% of residents

are living in poverty. For Hispanics, the 2010 poverty rate was 17.7% county wide. For African Americans, these rates were 21.1% adults and 17% children living under the federal poverty level.

2.3 Health System Description. *[No more than 250 words]* *153*
Describe the components of your health care system, including license category, bed size, number of clinics, specialties, payer mix, etc.

The Palm Drive Healthcare District owns Sonoma West Medical Center, which is a general acute care district hospital, licensed for 37 beds and operating 25 acute care beds. Medical, surgical, and intensive care services are provided on an inpatient basis. Emergency services are provided 24 hours a day, seven days a week. Ancillary services include. Cardiopulmonary, Clinical Laboratory and Pathology, Endoscopy, Hospitalists, Intensive Care, Medical Imaging, Rehabilitation Care (which includes Physical Therapy, Occupational Therapy and Respiratory Therapy) and Surgical Services. The hospital also uses InTouch Telemedicine ,"I Robot" to increase access to specialty care physicians in the ER and in-patient units.

The hospital employs or contracts with approximately 180 FTEs and is non-unionized. The staff at SWMC is approximately one-third bicultural with a quarter of the staff being bilingual. The hospital is accredited through Del Norske Veritas (DNV).

The hospital has an out-patient surgery service as well as out-patient laboratory and imaging services.

SWMC payer mix Jan-April 2016-56.5% Medicare, 16.6% Medi-cal (managed and traditional), 18.2% commercial, 9% self pay and other.
SWMC is partnering with Sonoma West Health Center for post acute care transitions for Medi-Cal and uninsured patients to improve access and services for the Medi-cal population. SWHC is responsible for the majority of Medi-cal members in the west part of the County-15,000 out of 20,000 total members.. The payer mix of SWHC is 43% MediCal,14% healthy families, 22% Medicare,20% uninsured / self pay.

2.4 Baseline Data. *[No more than 300 words]270*
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.

The Performance Improvement Program is led by the Performance Improvement Director. The committee includes representatives from Medical Staff departments, risk departments and clinical departments. The support and clinical departments include out-

patient services. The scope of the PI Program is to evaluate organized services and processes, both direct and supportive, including services provided under contract. The monitoring includes the use of internal audits defined by SWMC and Regulatory bodies such as DNV, which is deemed by CMS and California department of Public Health for accreditation.at scheduled intervals. Measurement, monitoring and analysis of processes throughout the organization has established measures that have the ability to detect variation, identify problem processes, identify both positive and negative outcomes, and effectiveness of actions taken to improve performance and or reduce risks. The metrics described in the PRIME initiative will be folded into the SWMC performance improvement agenda.

The hospital opened October 30, 2015 using a newly developed EHR program, "Harmoni", and queries are being developed to extract data for quality and performance improvement measures. In the meantime systems have been developed to collect quality data manually.

The FQHC community clinic partners with which SWMC collaborates has been reporting on mandated outpatient measures for several years. The FQHC also participates in an Accountable Care Organization that has been collecting data for population health management. The baseline data in the community clinic can be used to model hospital data collection processes to ensure clinical outcomes are met. The Performance Improvement Director will ensure that the data needed for the mandated clinical outcome measures for Care Transitions are collected, monitored and reported.

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] 544
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.140

SWMC overarching goal is to improve the health of our patients by providing culturally competent, evidence-based, person-centered care to the rural communities it serves. As part of PRIME, SWMC intends to implement more effective approaches to care management and care transitions to guide patients and their families through the full continuum of care, reducing avoidable readmissions. This will support delivery system transformation in that SWMC will be better able to provide whole-person care in the setting that is best suited to the patient's clinical and social needs. The Care Transition Team will use appropriate, evidence based models such as the Coleman Transitions of Care Model that has been shown to reduce readmission rates and improve patient outcomes.[12] The care transitions project provides smooth transitions of care from in-patient and emergency care to a wide array of community partners working toward the same goal.

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. 82

Through focus on our selected PRIME project in Care Transitions SWMC will implement a patient-centered, community integrated delivery model that:

1. Strengthens our partnership with West County Health Clinic to ensure seamless transitions of care

2. Identifies and targets high risk populations, improves patients' self-care capabilities, and optimizes patients' course of chronic illness

3. Ensures that care delivery is appropriate and coordinated, effectively transfers health care responsibility to the next appropriate health care resource.

4. Prevents 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;* 130

SWMC has selected one project for PRIME-- 2.2 Care Transitions: Integration of Post-Acute Care. SWMC will collaborate with community providers to expand its clinical services in alignment with care management principles, and to expand access to community providers along the continuum of care. The hospital will focus on the needs of individuals with COPD, CHF, diabetes and mental illness and substance abuse

consistent with the identified health disparities in its service area. There will be a focus on patients with these chronic conditions, who are not easily connected with care due to rural isolation and those unable to commit to continued care. Through the adoption of evidence-based guidelines our clinical care management teams, including those in primary care, will provide support aimed at improving patient self-care and reducing avoidable emergency department visits and hospitalizations for persons with these conditions.

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
NA

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.196

SWMC/PDHCD's   transformed delivery system will enhance care coordination across the care delivery system. This will be done by collaborating and partnering with community resources including West Sonoma Healthcare Clinics, West Sonoma Homeless Shelter, West Sonoma Respite Mental Health Program, Paramedic home support services, skilled nursing facilities, and home care to provide the right care for its Medi-Cal patients that may be homeless and suffering from chronic complex health issues. Transitions will be seamless because community partners will come together to address gaps in care.   The hospital will improve revenue through use of new Care Transitions codes.   Patients will be healthier because the care management team has provided support to instill confidence in self-care in the home and community. Clinical outcomes will be improved for recipients of care management services as reported in the PRIME metrics.

The development of a care management team is documented to be the single most important change that a health system can make in that its broad-reaching impact spans patient experience (through integrated care), improved clinical outcomes (through enriching patient relationships and enhancing patient engagement), and reduced cost of health care overall by eliminating duplicate testing and preventing avoidable ED utilization and/or hospitalization.[10]

Meeting Community Needs. [No more than 250 words]153

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.

In partnership with the West County Health Centers, EMS agency, local Fire Districts and Ambulance companies, Sonoma County Mental Health Services and other healthcare partners, the hospital will provide care to patients in the community who will receive in-patient and out-patient care, and return to their homes and their community with the support that is needed to continue to recover.   SWMC will adopt the Coleman model that currently is in practice at the West County Health Centers, which provides clear guidelines for care transitions interventions.   Through effective care management, we anticipate reduction in avoidable emergency department visits for ambulatory care sensitive conditions. Individuals with chronic disease and mental health needs will be educated on health care resource utilization, and will be aligned directly with a care manager for support which will enable the patients to more confidently manage their own care in the home and community setting, thereby reducing avoidable hospital admissions.

3.2 Infrastructure and Alignment with Organizational Goals. [No more than 250 words]146
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).

SWMC and the Palm Drive Healthcare District have a broad vision for delivery system care transitions, and are committed to improving care transitions for the chronic conditions they treat into the transitions of care initiatives. This commitment reaches out to all community partners in this vision of care for the community.

The SWMC Performance Improvement Director will assume primary responsibility for PRIME project oversight. Project metrics will be added to the Performance Improvement program. Trended reports will be followed regularly; opportunities for improvement will be identified and interventions designed as appropriate.   Data reports will be shared with the clinical teams, the performance improvement committee, the SWMC/PDHCD leadership, and the Board of Directors in on a quarterly basis. Patient feedback will be obtained through the local Patient Advisory Council, which will include questions designed to elicit responses which reflect patient experience in the new environment of care.

3.3 Stakeholder Engagement. [No more than 200 words]192
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.

SWMC has convened a Care Transitions Committee comprised of SWMC, Sonoma West Healthcare Clinics, Homeless Shelter and Mental Health Respite beds; working to assure success of the Care Transitions process across organizations. The committee is collaborating to identify gaps in care and resources within the community to fill those gaps. The committee is committed to avoiding redundancies in care transition services and supporting all components of the care network .The close physical proximity of the community partners, primary care providers and mental health services promotes ease of communication among entities, as well as ease of patient care transition.

Through PRIME project implementation, SWMC will engage community stakeholders in planning efforts to ensure that local health resources are adequate to support the continuum of care. This level of engagement will result in enhanced relationships with the community based organizations.
A shared vision for this plan has been developing for some time, and it is with great anticipation that these entities look forward to using the PRIME resources to implement the PRIME program.

Sonoma West Medical Center will engage individual community members through focus groups and surveys to gather data from the consumers about the quality of their care and transitions to other providers.
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3.4 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.132

The Hospital and District are committed to ensuring the needs of our diverse patient population are met, including linguistic and cultural competency. All employees, at the time of orientation to the hospital and annually, are engaged in mandatory training for cultural competency that is designed to meet the needs of the community served. The hospital employees are approximately 30% bicultural and about 50% bilingual
Print materials are available in English and Spanish (our identified threshold languages), including health educational materials. SWMC provides real-time access to interpreter services in the patients' language of choice through the well-established AT&T Language Line which provides access to over 140 languages, 24 hours a day, and 7 days a week. For patients with hearing impairment, the hospital provides an American Sign Language interpreter on site, if necessary.
Sonoma West Medical Center will ensure that the collaborative post acute care transitions committee addresses disparities in healthcare services for its patient population.   Hispanics represent 26% of the western part of Sonoma County. Due to high rates of obesity and diabetes in the Hispanic community SWMC and SWHC will

enhance services for diabetic post stabilization services in both the clinics and at home. We will continue to monitor community health data to identify and address healthcare disparities in the development of our services under the 5 year plan.

3.5 Sustainability. [No more than 150 words]198

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.

After an 18 month closure due financial losses, the directors of PDHCD, hospital leadership and the community came together to reopen the hospital in October 2015. This was to address the need for hospital services in the remote communities of Sonoma County, as well as the reduction of beds in a local hospital. This same team is committed to improving the health of the SWMC community and is already working collaboratively. The PRIME team includes WCHC and their Homeless Mental Health care team representatives. The shared vision for care transitions has been developed and will be leveraged to ensure the success of the project. This team will oversee the formal adoption of best practices in care transitions and ensure staff development on care transitions principles and workflows. Positions dedicated to care transitions will be identified. Partnership agreements to ensure post-acute care resources are available will be developed under the infrastructure building measures.

At the end of the 5 year Program; SWMC will have developed new methods of capturing revenue for care transitions and alternative payment methodologies to cover the costs of the program and will be optimizing the use of the EHR for clinical documentation and reporting.

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

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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 (is) 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 <u>each</u> 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. **<u>For DMPHs (as applicable),</u>** *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.*

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

Rationale: The SWMC/PHCD is facing significant challenges ensuring safe and well-coordinated care transitions, including.   1) difficulty obtaining post-acute care services for the increasing Medi-Cal population; 2) a high readmission rate for some diagnoses and 3) the lack of adequate community health care and housing resources to support patients as they leave the hospital.

SWMC admissions data reveals the majority of patients are admitted for COPD, CHF, and/or diabetes, often with pre-existing mental health or substance abuse issues. Many of these patients have documented complex health problems and due to rural isolation, are unable or unwilling to return for follow-up care with their primary care physician.

Implementation Plan: SWMC will continue to develop partnerships in the community in order to meet care transition goals. Through early assessment and intervention, the care team will detect which clients will need consistent support for recovery and how to address barriers to access and willingness for care. Sonoma County provides In-Home Supportive Services (IHSS), including assistance with meal preparation and clean-up, food shopping, bathing, dressing, and house cleaning. Including their services in care transitions to home will be beneficial to our patients.

The SWMC/PDHCD ED Discharge follow-up call program is currently reaching 25% of patients admitted to the ED and discharged home. Staff utilizes a script to assess care issues and need for further care transitions. Staff help patients resolve any issues and make appropriate referrals and appointments for follow up. 25% outreach is a high baseline to build upon, demonstrating the early success of the program. This program will be expanded to increase the percentage of care transitions calls. Quality data from these calls will be monitored for opportunities to improve care and will be reported to the Performance Improvement Committee. SWMC/PDHCD will also develop community options for mental health referrals and can assist with developing these services in the community. Increasing collaborative partnerships will help to build resources for mentally ill and substance use disorder patients.

1. Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]155

A collaborative care management approach to transitions of care will ensure the coordination of health care resources for patients, improve the patient's experience of care, and ensure safety. In coordination with West County Health Centers and the new homeless mental health clinic operated by WCHC services will be provided to behavioral health patients, improving care transitions and resources for the homeless. These include rapid rehousing services. Collaborating with multiple partners to bring care to the patient will improve clinical outcomes for Medi-Cal and underserved people.

The clinical team will focus and increase their efforts at outreach and follow-up of patients. Through intentional health education, coaching, and personal goal setting, patients will become more confident in self-care, allowing the patient to successfully self-manage while in the home and community. They will follow care guidelines and keep out-patient appointments. In-home care and support will strengthen the patients' ability to follow with the continuum as they become stronger.

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.
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.

Check, if applicable	Description of Core Components

	• 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.
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

Check, if applicable	Description of Core Components
	services is in place.
Not 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 $ 1,147,000

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 1. Infrastructure Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Start and End Dates
1.	Begin data collection immediately on all mandated hospital core measures to allow for baseline EMR updates for data – determine methodology to collect required quality Data retro to opening in Nov. 2015	Data is available and included in first report on required core metrics • Data field identified and mapped to reports for PRIME reporting • Prime reports written and replicable for continuous reporting	2.2	June 1 2016-September 30 2016
2.	Collaborate with existing care transition programs to prevent redundancy.	Relationships formalized via written MOUs with care partners: • Primary care clinics, primarily WCHC • Hospital based services • Participate in the County Committee of Health care Transition providers.	2.2	J- June 1 2016-Sept 30 2016
3.	Explore relationship/collaboration with West County Health clinics, homeless shelter and respite beds and rapid re-housing.	Formalize the relationship with West County Health Center to determine a collaborative response to post acute care transitions and to determine the mutual benefit to our patients with clear responsibilities for the clinic and the hospital; including budget development and resource sharing for patient care. MOU developed with West County Health centers mental health program for 3-4 respite beds for mental health and rapid re-housing services.	2.2	-June 1 2016-Sept 30, 2016
4.	Explore relationships with Sonoma County mental health to enhance care transitions for mental health and Substance	Form relationship with County mental health to ensure behavioral health patients receive timely access to care. MOU or contract to be developed	2.2	June 1, 2016-Sept 30, 2016

	used disorder patients.			
5.	Identify alternative health care providers, such as skilled nursing facilities or Board and Care homes for transitional care.	Develop relationships, contracts with care transition partners to ensure appropriate access to lower levels of care such as local skilled nursing facilities. Develop SNF plan for all MediCal patients to ensure access documented in an MOU with the appropriate facilities.	2.2	-June 1 2016- Sept 30 2016
6.	Develop a training program on selected evidenced based care transitions model.	Formal written program is developed and mandated for appropriate care transitions staff. Program includes training in care management, care transitions, discharge planning and population health management strategies. 27 nurses in various department will be trained.	2.2	June 1 2016-Sept 30 2016

Appendix 2. References

1. Sonoma County Community Health Needs Assessment Sonoma County 2013-1016

2. Chronic Disease Fact Sheet: Coronary Heart Disease – Sonoma County 2009

3. Chronic Disease Fact Sheet: Diabetes – Sonoma County 2009

4. Chronic Disease Fact Sheet: Chronic Lower Respiratory Disease – Sonoma County 2009

5. Sonoma County Community Health Needs Assessment Sonoma Count 2013-2016
6. Ibid

7. United States census Bureau, 2014-American Fact Finder

8. Ibid

9. US Census Bureau, American Community Survey 2014

10. Applied Survey Research Sonoma County Homeless Census and Survey 2015

11. Sonoma County Community Health Needs Assessment Sonoma County 2013-2016

12. California Healthcare Foundation Care Transitions Project Final Progress Reports and Meetings Summary 2009