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	Washington Hospital Healthcare System
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.

Washington Hospital Healthcare System (WHHS) is an acute care Magnet designated not-for-profit District facility in Fremont. It has served as the primary public safety net hospital in southern Alameda County since 1958.

Community health care needs/disparities:

Every three years WHHS conducts assessments to ensure it is recognizing and meeting District healthcare needs.

Recent data shows heart disease, diabetes, stroke and hypertension are major disparities affecting the District population, with rates among the highest in Alameda County and California[1] (**Table 1**). Internal data shows an unprecedented increase in Emergency Department volume (23%) over the past decade.

Beyond these disparities, specific health care needs have been identified through our Internal Needs Assessment, US Census Bureau and Office of Statewide Health Planning and Development data:

Need for Prenatal Care

There is limited access to prenatal care within the District and no perinatologists at WHHS. Gaps in care exist particularly for low-income Medi-Cal patients, already at risk for poor pregnancy outcomes and travelling over 20 miles to the nearest Medi-Cal-accessible clinic for prenatal care. With transportation barriers, largely Medi-Cal deliveries (24%) and an Asian (44%) population ethnically at high risk for low-birth weight deliveries and diabetes, the need for prenatal care and coordination post-delivery are imperative to ensure positive outcomes.

Need for Palliative Care

There are no comprehensive inpatient palliative care programs in southern Alameda County and no palliative care-certified WHHS physicians, which leads to gaps in care. Beyond general community needs, with a culturally diverse population and different values on treatment of chronic illness there is a need for culturally-appropriate palliative care. Based on Center to Advance Palliative Care estimates on the need for palliative care[2] and WHHS FY 2014 admissions, annually as many as 650 District residents would benefit from inpatient palliative care and improved patient experience[3].

Need to Further Improve Imaging Efficiency

With advances in technology, there has been an increase in imaging utilization without sufficient evidence-based indication. There is a need to improve efficiency, while focusing on appropriateness of utilization. Responsible use of imaging in a limited resource setting and utilization of electronic health records to review past history, will lead to improved access and continuity of care.

Gaps to coordinated care exist particularly for Medi-Cal patients in the District. Through the opportunity presented by PRIME, WHHS aims to make prudent use of resources to offer relevant, high quality evidence-based medicine, while transforming the delivery system and meeting community-specific needs.

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.

The hospital provides ready access to care primarily for residents of Fremont, Union City and Newark, i.e. - the Washington Township Health Care District. The area served is approximately 124 square miles and the District's population is over 330,000.

Income

Median per capita income in the District varies by zip code, ranging from $61-$138k and unemployment rates ranging from 1.6% to 12.7% (**Table 2)**.

Age

The District has an aging population (**Table 3**) with 10.6% (n=22,838) of the population of Fremont over the age of 65 years[1]. Of these residents over 65 years, 35% have a disability and 5,174 individuals are living on less than 200% of the federal poverty level (**Table 2**).

Race and Ethnicity

Washington Hospital is unique in that it serves a highly diverse patient population (US Census Bureau, 2011) with 44% Asians, 26% White, 21% Hispanic, 4% African American and 5% Other/More than one race (**Table 4**). The Asian ethnicity encompasses several groups: 17% East Indian, 14% Filipino, 8% Chinese, 3% Vietnamese, and 2% other Asian.

Primary Language

With a large immigrant population in the District, more than 130 languages are spoken by residents[1]. Non-English primary languages spoken among patients include: Spanish (30% of non-English primary language), Mandarin (14%), Farsi (13%), Punjabi (10%), Cantonese (7%), Tagalog (6%), Hindi (5%), Vietnamese (4%), Arabic, Dutch, French, Italian, Japanese, Korean, Polish, Portuguese, Russian, Romanian, Swedish and Urdu (≤1% each) [2]. Between 9.2% to almost a third (30.4%) of zip codes in the District report 'Limited English' knowledge (**Table 5**).

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.

License Category, Bed Size, Services

WHHS is a 341 bed acute care hospital operated by the Washington Township Health Care District. As the major public hospital of southern Alameda County it provides 24-hour emergency care with over 50,000 visits per year (Medicare 'High' volume ED)[3]; childbirth/family services; cardiac surgery, catheterization and cardiac rehabilitation; Intensivist-directed critical care; nutritional counseling; outpatient surgery; pulmonary function; crisis intervention; respiratory care; rehabilitation services (cardiac, physical, speech, occupational therapy); social services; laboratory; medical imaging; level II nursery, hospice, spine care, sports medicine and has been a Joint Commission-certified Primary Stroke Center since 2007.

Clinics and Specialties

WHHS has three urgent care clinics and numerous primary and specialty care clinics including cardiology and cardiothoracic surgery, endocrinology, gastroenterology, geriatrics, neurosurgery, oncology, orthopedic and sports medicine, otolaryngology (ENT), pediatrics, pulmonary medicine, urology and vascular care.

Collaboration with UCSF

Washington Hospital's mission is to offer the highest level of care within a comprehensive and integrated regional health care network. To further that goal, the Hospital has a strategic relationship with UCSF Medical Center and Benioff Children's Hospital (since 2013).

Patient Population

In FY 2016 (through February), WHHS had 8,021 admissions and 56,603 outpatient visits The largest proportion of the patients presenting were Medi-Cal/Medi-Cal HMO (40.5%), followed by Commercial (26.3%), Medicare/Medicare HMO (23.9%), and Self-Pay (7.8%) **(Table 6). For complete description of utilization see Table 10.**

Awards (Table 7)

- Awards for high quality care and service recognition
- American Stroke Association Get With the Guidelines Gold Plus Awards
- National awards for cancer care/radiology

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.

WHHS has a longstanding tradition of data-driven organizational decision-making. WHHS's Quality and Resource Management (QRM) Department serves as the data warehouse for organization-wide data. It is led by a Senior Director with clinical experience (doctorate in nursing practice) and background in quality/infection prevention. QRM is supported by four quality coordinators, a biostatistician and a dedicated Quality Advisor physician with deep clinical knowledge and expertise in healthcare quality.

Data Collection

QRM uses nationally standardized definitions for data collection. WHHS's electronic medical record system (EPIC) was launched in 2013, streamlining the process of collecting data. QRM works alongside the Information Services division to ensure data accuracy and validity. With a single source and clearinghouse, the process of data collection is simplified and streamlined organization-wide.

Reporting

Data are reported hospital-wide through Quality Steering and unit-level committees, from executive level to clinical staff, publicly to the community and to the hospital board of directors on a quarterly basis using reports, charts and dashboards. Data are also reported externally to a number of national quality registries and databases (**Table 8**).

Monitoring Performance

Quality reports are reviewed quarterly to evaluate performance and identify improvement opportunities. Dashboards are used to track department-specific quality metrics. Data are analyzed for statistically significant changes over time and reviewed to monitor the effectiveness of quality initiatives. Data-driven action plans are devised and modified based on performance.

PRIME Reporting: WHHS has started collecting baseline data required for PRIME on available metrics. EPIC reports are being built to meet reporting requirements and understand barriers proactively.

Limitations & Strategies: While the reporting infrastructure for metrics will be created, staffing resources to monitor data is limited. With support from PRIME, WHHS has plans to appoint dedicated staff to be responsible for data collection, reporting and to review metrics and data on a real-time basis.

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.*

In line with Washington Hospital's strategic plan and based on an assessment of the District needs, the goal for the PRIME plan is three-fold:

- Increase access and care coordination in identified areas of need
- Provide the highest quality care using evidence-based practice
- Manage cost and improve patient experience

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.*

Our strategic goals will be met by three specific aims as part of our selected PRIME projects, to improve population focused services with enhanced quality and sensitivity to cost reduction:

- With establishment of a Prenatal Diagnostic Clinic (PDC) in collaboration with UCSF, we aim to provide comprehensive local care coordination and access to timely prenatal/post-partum care, thereby changing the maternity care delivery system in our District. We hope to reduce the frequency of crisis deliveries (including obstetrical hemorrhage, cesarean-sections) among high risk women which result in lengthy neonatal intensive care services. The program will also support breastfeeding initiation/continuation post-discharge, in accordance with our Baby Friendly designation.

- With establishment of an Inpatient Palliative Care Program (IPPC), we aim to provide an adjunct to the treatment of serious illnesses and end of life conditions that focus on reduction of pain and symptom management. The IPPC will help to coordinate and manage a comprehensive approach to improving the patient and family experience with the reduction of length of stay and unnecessary higher level of treatment. As the IPPC program matures, the development of outpatient services will evolve with the goal of increasing access, reducing acute care admissions, and reducing costs.

- WHHS has already begun its lean journey. The work in imaging will affect areas hospital-wide including its high volume emergency department, inpatient units, outpatient units, staff and patients. The focus will be to reduce inpatient and ED length of stay by streamlining the care process through lean (Kaizen) improvement work. We plan to identify and implement a clinical decision support tool to assist providers with evidence-based guidance to utilize the most appropriate imaging study. With this we aim to improve quality of care, and reduce costs.

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;*

Through PRIME, WHHS hopes to transform its healthcare delivery system with the comprehensive support of identified District needs, while providing culturally-appropriate care. Smart and appropriate use of resources through Lean methodology will help fulfill goals of the healthcare system and directly correspond to our project aims. The projects selected aim to increase access to appropriate care, while managing costs and improving quality through care coordination and evidence-based practice.

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);*

The three projects selected inter-relate, as the overarching goal is to transform care delivery in identified areas of need, optimize care provided in the District and improve patient experience. System transformation occurs when healthcare needs can be met within the community. With the coordination of care using a multidisciplinary, evidence-based approach, in all three projects, we expect to advance the system by improving quality while reducing costs. Each project involves multi-disciplinary teams and comprehensive plans for community engagement throughout the process.

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.*

WHHS visualizes a health system where District residents will receive critically essential services and access to care at the local level, while preventing unnecessary services leading to increased costs and undue risk for patients. Through Prime, the establishment of a Prenatal Diagnostic Clinic and a Palliative Care Program, WHHS anticipates further improvement in patient outcomes through improved access to high quality and timely individualized care. With our Lean Imaging program and implementation of a decision support tool, we expect to see an improvement in evidence-based standardized practice and a reduction in costs. With support from PRIME and establishment of necessary infrastructure, WHHS will continue to serve the needs of the community in a post-PRIME transformed environment.

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.

Currently there is limited local access to prenatal care and no perinatologists on staff at WHHS. Therefore inpatient consults for high risk mothers who present to WHHS are currently not available. Through establishment of the PDC and 24/7 access to UCSF phone consultation we hope to provide immediate access to care from pregnancy through the post-partum period within the District, and eliminate the transportation barrier experienced by Medi-Cal patients. By ensuring adequacy of care and support through the delivery process, we hope to better manage co-morbidities among high risk patients to optimize outcomes.

Currently there is no inpatient or outpatient palliative care program within our highly diverse District, resulting in limited access to culturally sensitive palliative care. A palliative care program with an individualized, culturally-tailored approach will provide early and effective access. Through care coordination post-discharge, we hope to manage costs while enhancing patient experience.

With the Affordable Care Act, more patients have access to health insurance, yet inappropriately utilize the emergency department for primary care services. This results in incomplete medical records and numerous ancillary studies to determine a diagnosis. The clinical decision support tool to be developed through the lean approach to high cost imaging will alert physicians to review previous medical history. If no history is

available, the tool will also guide physicians, based on patient symptoms and examination, to choose the most appropriate imaging studies, in a constrained resource environment.

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).

As the primary Hospital District in the area, in line with its strategic and organizational goals, Washington Hospital is committed to meeting the healthcare needs of its community.

The hospital embodies a culture of patient safety while adopting identified best practices.

Washington is committed to implementing PRIME projects with active oversight and engagement of executive staff through the process. The approach to PRIME is multidisciplinary involving Finance, Nursing, Physicians, Quality and Resource Management, Strategic Management and the Lean Promotion Office (detailed capacity of involvement of different departments and the process of quality improvement is listed in Tables 11, 14 of the Appendix).

Mechanisms have been established for data collection and standardized reporting through dashboards with comparison to national benchmarks and specific goals. The planned infrastructure will facilitate implementation of the projects. While monitoring of data will be ongoing with the help of a dedicated PRIME manager (Table 11), we plan on a multidisciplinary monthly review of metrics and evaluation of efforts to meet performance goals and standards.

Updated results of performance will be given to executive staff and our Shared Governance reporting structure on a quarterly basis. Based on quantitative results of performance and qualitative feedback from internal and external stakeholders, we aim to make data-driven decisions to optimize the process of project implementation.

With strategic affiliation and collaboration with UCSF, we will receive ongoing support and feedback from established connections with clinical expertise in project areas.

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.

The primary stakeholder is the community member who benefits from high quality, coordinated care within the District. Currently periodic patient experience surveys are done on a regular basis and patients are encouraged to provide feedback, with the goal of continuous improvement. This data is evaluated monthly by Washington Hospital's Patient Experience Committee and shared hospital-wide.

As part of our PRIME projects, we plan to conduct community focus groups to receive feedback, from the planning stages through implementation and establishment of programs.

WHHS has a strong history of providing education in the community through outreach programs, our local cable channel and health fairs. With the implementation of these projects, we plan to expand these efforts to increase awareness of new resources.

Progress towards implementation of programs will be shared with internal stakeholders through dashboards and disseminated transparently to the community through our open District-elected board of director meetings.

As the primary public safety net hospital in southern Alameda County, Washington Hospital has existing relationships with community physicians, skilled nursing facilities, home health agencies, hospice programs and strategic relationships with UCSF and clinical experts. We plan to continue our partnership with these stakeholders to ensure care coordination throughout the District.

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.

Washington Hospital has long recognized and supported the diversity of the District and cultural competency is woven into the fabric of the system. The diversity of our community is reflected in the diversity of our staff **(Table 9).** This is also reflected through the number of languages spoken by staff. Cultural competency is "built-in" with sensitivity to the unique needs of this community.

- To **reduce language disparities**, WHHS utilizes a translational service ('Cyracom Technology') with capability to translate up to 150 languages. This service will be used as part of our PRIME projects.

- To **ensure cultural competency**, all employees are trained at orientation and evaluated annually through an electronic learning system ('SABA'). All PRIME project staff will be required to undergo this training and evaluation.

- Community partner **resources**, such as volunteer chaplains of different faiths give their time to help ensure patients' cultural needs are met.

- Each project will have **specific strategies to reduce culture-specific healthcare disparities**, through individualized approaches to care. For example, with our palliative care project, a nurse practitioner and spiritual care nurse will perform cultural assessments at admission to gain a deeper understanding of cultural/religious needs and develop a plan of care based on patient needs.

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.

PRIME funding would help WHHS provide critically essential services and establish infrastructure using best practices to transform care in the District. With this support, we expect improved quality of care, patient outcomes and cost savings in the District.

The program will continue to serve the needs of the community and sustain improvement by the following specific components:

- WHHS is committed to a Lean organizational culture and approach to quality improvement. Inherent to this approach is to focus on sustaining the future state beyond implementation through continuous process improvement.
- Our historically engaged, Quality and Resource Management department focuses on sustainability of initiatives. Through the infrastructure developed as part of PRIME, progress and performance will continue to be monitored post-PRIME with ongoing analysis from the Quality Department.
- WHHS executive staff provides a strong foundation with data-driven decision making, and are actively involved in design and implementation of PRIME projects.

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

☒ 2.1 – Improved Perinatal Care (required for DPHs)

WHHS will require infrastructure building measures for this project. These are included in Appendix-Infrastructure Building Process Measures.

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]*

WHHS provides the only available Level II Special Care Nursery. The addition of comprehensive perinatal services completes the care continuum for patients served by the hospital, particularly among residents who currently travel 20 miles to receive prenatal care. Secondly, the District has a pregnant population who are ethnically and socioeconomically at high risk for co-morbidities and poor infant outcomes. Adequate prenatal care, support post-partum and care coordination should result in improved maternal and child outcomes among this high risk population.

Via the WHHS affiliation with UCSF, it was determined that a prenatal diagnostic clinic operated by WHHS and staffed by UCSF medical doctors (24/7 phone consults) would provide valuable and much needed clinical service to expecting mothers living within the Health Care District. The PDC plan, including specific patient care services as shown below are also listed at Table 12 in the appendix.)

Detailed Description of Services Provided by the Perinatal Diagnostic Clinic

Scope of services of the PDC includes: amniocentesis, diagnostic ultrasound, and genetic testing and counseling. Fetal echocardiogram and fetal brain MRI can also be done in San Francisco, if necessary, through our partnership with UCSF.

More specifically:

Service Model for Screening

- First trimester blood work will be ordered by referring clinic at 10 ½ weeks (done with routine prenatal labs). Patient will be coached to have lab drawn about 1 week prior to scheduled NT ultrasound in order to be able to receive an instant result
- Patient or provider will refer patient to PDC to schedule NT ultrasound
- PDC staff will communicate with Prenatal Screening Lab to gain access to patient lab entry, and will calculate first trimester aneuploidy risk:
    - ✓ If biochemistry is processed and available, patient will receive instant result at the conclusion of her ultrasound visit, with a face to face discussion with a genetic counselor. Counselor will provide interpretation of result, and prenatal diagnosis will be discussed depending on value of risk and specific preference of patient
    - ✓ If biochemistry is not available, the patient will be contacted by phone with the result, by a genetic counselor, as it is available. A separate summary note documenting phone communication will be generated.
- Second trimester screening will be ordered by the referring clinician at 15-18 weeks
- Second trimester or Integrated results will be obtained by PDC from State Screening Program when patient is seen in PDC for second trimester ultrasound
    - ✓ Specific result will be discussed with the patient by the clinician at the time of her ultrasound, with interpretive analysis of serum marker values and any associated risk for adverse outcome (increased surveillance recommended and documented in summary letter)
    - ✓ Depending on actual value of aneuploidy risk and in the context of any ultrasound findings, patient may be offered prenatal diagnosis.

Communication of results

- Abnormal ultrasound findings will be discussed with the patient at the point of service and called to the referring practice on the same day
    - ✓ If the referring provider's office is closed when the anomaly is identified, a message will be left, if possible. Alternatively, the practice will be contacted on the next business day
- All procedure notes will be finalized on the day of service and electronically transmitted or faxed to the referring provider at the end of the business day
- If a maternal indication or ultrasound finding suggest any follow-up studies, we will schedule follow up appointments and notify the referring provider to request a requisition or order prior to the scheduled appointment
    - ✓ If it is necessary that the study be coordinated by the referring provider (based on specific insurance for example), this will be clearly communicated in the summary note
- Perinatal consult summaries and notes summarizing multiple studies (fetal echocardiogram, fetal brain MRI (which would be performed in San Francisco), will be sent to the referring provider as soon as finalized

        - ✓ Abnormal findings will be discussed with the patient at the point of service and called to the referring practice on the same day
- Cytogenetic and/or molecular results will be communicated to the patient by phone, by a genetic counselor, as soon as they are released.
    - ✓ Abnormal findings communicated to the referring provider by phone and/or electronically transmitted/ or fax on the day they are released.
    - ✓ All patients with an abnormal result offered in person consultation with a Prenatal Clinical Geneticist.
    - ✓ Summary notes with cytogenetic and/or molecular studies mailed to the practice once reviewed and signed by PDC prenatal clinical geneticist

Our planned approach to implementation:

Phase 1 (Demonstration Year 1): Planning and Start Up

- WHHS will make space improvements and furnish the PDC clinic and recruit a UCSF perinatologist to staff the clinic. All internal and identified external community stakeholders will be educated on the policies, procedures, protocols and goals. Community outreach will increase awareness among District residents.
- Baseline data will be collected and evaluated. A methodology to document and report new metrics will be established

Phase 2 (Demonstration Years 1-5) PDC Operational

- Data on process and outcome measures will be collected and evaluated for progress of the prenatal and post-partum period. Metrics will be evaluated to ascertain sustainability.
- Coordination of care with community providers ensures achievement of target goals.

Phase 3 (Post-PRIME) Plan to Sustain

- It is expected that the volume of higher/high risk deliveries at WHHS would increase over the first five years due to the presence of the WHHS PDC. Some of these deliveries would result in a higher NICU/SCN census, which would financially support the PDC's expected financial losses.

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

The target population is 100% of expecting mothers in the District, with emphasis on patients at high risk for a complicated pregnancy or delivery.

Based on an analysis of Fiscal Year 2013 WHHS obstetric volumes, it is estimated that approximately 1,000 District residents would utilize the PDC in an average year, resulting in approximately 1,800 annual visits (average of 1.8 visits per patient). Included in this estimate are all Washington Township Medical Foundation expecting mothers and 50% of the private, community OB expecting mothers. Approximately 10% are expected to have Medi-Cal insurance and 14% are anticipated to have Medi-Cal HMO insurance, resulting in approximately 1 in 4 patients with Medi-Cal insurance. Approximately 0.6% of patients have no insurance.

Lack of prenatal care can lead to high risk cesarean sections while raising costs and increasing risk of complications. The prenatal period offers a unique opportunity to optimize pregnancy outcomes. Through the establishment of a prenatal care clinic, adequate/timely prenatal care and support/education on breastfeeding (ensuring optimum infant nutrition) during the post-partum period, we hope to prevent morbidity and mortality among pregnant women newborns. By early identification of the risk of complications such as post-partum hemorrhage, we hope to either prevent them or minimize their impact.

High risk women with co-morbid conditions such as diabetes will be among those followed up post-partum. By providing early, continuous and comprehensive prenatal care services and post-partum follow up, WHHS hopes to ensure healthy pregnancy outcomes and reduce prenatal and perinatal complications in the District.

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

Check, if applicable	Description of Core Components
Applicable	**2.1.1** DPHs/DMPHs engagement in best practice learning collaborative to decrease maternal morbidity and mortality related to obstetrical hemorrhage (CMQCC/PSF/HQI combined effort).
Applicable	**2.1.2** Achieve baby-friendly hospital designation through supporting exclusive breastfeeding prenatally, after delivery, and for 6 months after delivery and using lactation consultants after delivery.
Applicable	**2.1.3** Encourage best practice and facilitate provider education to improve cesarean section rates, and decrease inequities among cesarean section rates. Participate, as appropriate, in statewide QI initiatives for first-birth low-risk cesarean births.
Applicable	**2.1.4** Coordinate care for women in the post-partum period with co-morbid conditions including diabetes and hypertension.

☒ 2.7 – Comprehensive Advanced Illness Planning and Care

WHHS will require infrastructure building measures for this project. These are included in Appendix-Infrastructure Building Process Measures.

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]*

The approach has been to design and implement a palliative care program based on best practice guidelines and from a multidisciplinary standpoint. To ensure success, the hospital partnered with a well-established palliative care facility (UCSF). A multidisciplinary steering committee (including UCSF experts) met over many months to develop the proposal. The proposal was approved by hospital executives, and was presented to the hospital board in a public forum. The opportunity for community input was invaluable.

- Hospital leadership has valued and endorsed palliative care since it enhances the life of experience of patients and their families. The community asked for it. No formal inpatient palliative care resources exist in the community at this time. Budgetary constraints have limited the hospital's ability to put a program in place. A Palliative Care Committee, though, was formed in 2004. This committee has been meeting monthly since 2004 and slowly began to create the vision of an inpatient program. Policies and protocols were developed. Vital members of the team were hired or trained, but these efforts, alone, did not make a program.

- Central to a community-based Palliative Care program is an engaged and knowledgeable Nurse Practitioner (NP). (The opportunity provided by PRIME makes hiring an NP possible.) An NP coordinates the care and prescribes medications for symptom management based on program parameters. The NP will lead the multidisciplinary team The table below describes the activites and roles of members of the multidisciplinary team being lead by the NP, and is also included as Table 13 of the appendix.) and assure a comprehensive intake of patient information with the objective of shared goal identification with the patient and family. The NP will be able to follow-up with the patient after discharge to assure continuity of care. The NP role also makes the vital outpatient program possible. The outpatient program is the final link in a functional and effective community approach to palliative care.

- **Planned Activities, Roles and Responsibilities of Comprehensive Approach taken by the Palliative Care Team**

Palliative Care Team Member	Role and Responsibilities
Nurse Practitioner	Intake, assessment, ordering medication and treatment, follow up of patients and holds team together
Coordinator	Patient rounding, coordinates patient-family conferences, facilitates communication within the team
Spiritual Care Nurse	Focuses on spiritual healing and counseling, rounds on patients daily
Business Assistant	Maintains records, orders supplies, collects data, handles staffing/scheduling/time cards, other administrative duties
Medical Directors	Oversees nurse practitioner orders for medication and treatments, provides medical perspective and
Social Worker	Provides for community resources and social work needs of patients and families during their stay and at discharge
Administrator	Executive sponsor to help navigate the program

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

A formal palliative care program at WHHS enables the hospital to meet the growing need for focused and individualized care of serious chronic conditions and end of life illnesses in the community. Availability of palliative care is transformative in itself. The project focuses on improved access, reduced cost and high quality of care. Studies indicate that mature palliative care programs can expect that up to 7% of hospital admissions are appropriate for palliative care. This new IPPC consultation model offers physicians providing care a new avenue of expertise in a formal team approach. Palliative care requires expertise, and often time for prolonged patient/family conferences that many community physicians have not had access to before. The comprehensive approach using the many disciplines on the team assures that optimal care and treatment is achieved.

- Specialists with certifications in palliative care focus on the “whole person” and address the issues of spiritual care, emotional needs, social issues as well as the physical symptoms of the patient and family. This patient-centered approach is also value-centered.

- A comprehensive and coordinated inpatient palliative care program will lead the way to an outpatient program that will further improve access and reduce costs. Outpatient programs help patients stay in their homes longer with improved quality of life. This Palliative Care program will truly transform the care of patients in the community and provide a new adjunct to the management of serious illness and end of life care.

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

Check, if applicable	Description of Core Components
Applicable	**2.7.1** Establish or expand both ambulatory and inpatient palliative care (PC) programs that provide: • Total, active and individualized patient care, including comprehensive assessment, inter-professional care planning and care delivery. • Support for the family. • Interdisciplinary teamwork. • Effective communication (culturally and linguistically appropriate). • Effective coordination. • Attention to quality of life and reduction of symptom burden. • Engagement of patients and families in the design and implementation of the program.
Applicable	**2.7.2** Develop criteria for program inclusion based on quantitative and qualitative data: • Establish data analytics systems to capture program inclusion criteria data elements.
Applicable	**2.7.3** Implement, expand, or link with, a Primary Palliative Care training program for front-line clinicians to receive basic PC training, including advanced care planning, as well as supervision from specialty PC clinicians. Assure key palliative care competencies for primary care providers by mandating a minimum of 8 hours of training for front line clinicians in communication skills and symptom management.
Applicable	**2.7.4** Develop comprehensive advance care planning processes and improve implementation of advance care planning with advanced illness patients.

Check, if applicable	Description of Core Components
Applicable	**2.7.5** Establish care goals consistent with patient and family preferences, and develop protocols for management/control of pain and other symptoms in patients with advanced illness, including a holistic approach that includes spiritual and emotional needs.
Applicable	**2.7.6** Improve completion of Physician Orders for Life-Sustaining Treatment (POLST) with eligible patients and participate in the state-wide POLST registry.
Not Applicable	**2.7.7** Provide access to clinical psychologist on the palliative care team to address psychological needs of patient and the family members during the advanced illness and provide grief counseling and support to the family after death of their loved ones.
Applicable	**2.7.8** Enable concurrent access to hospice and curative-intent treatment, including coordination between the providing services.
Applicable	**2.7.9** Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice, including linkage with PC training program.
Applicable	**2.7.10** For advanced illness patients transitioning between primary care, hospital, skilled nursing facilities (SNFs), and/or home-based environments, ensure that the advance care plan is clearly documented in the medical record and transmitted in a timely manner to the receiving facilities and care partners who do not have access to the health system's medical record.
Applicable	**2.7.11** Engage staff in trainings to increase role-appropriate competence in palliative care skills, with an emphasis on communication skills.
Applicable	**2.7.12** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

Please complete the summary chart:

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

Section 4.3 – Domain 3: Resource Utilization Efficiency

☒ 3.2 – Resource Stewardship: High Cost Imaging

WHHS will require infrastructure building measures for this project. These are included in Appendix-Infrastructure Building Process Measures.

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]

Lean is a management methodology based on the Toyota Production System. Lean focuses on use of reliable, thoroughly tested technology and elimination of waste. High cost imaging services are a good fit for Lean since they are often fraught with waste related to access, turnaround, reporting speed, communication, and efficient functioning of equipment. Lean identifies ineffective routines and helps to create better workflows through hospital-wide collaboration. Through a series of lean improvement workshops, comprised of multidisciplinary teams of staff and potentially patients, the flow of imaging services will be optimized.

Washington Hospital will complete 3 process improvement workshops to reduce patient wait times for imaging studies. This will increase patient access for imaging studies. Washington Hospital will then implement a clinical decision support tool (CDS) to aid physicians in determining the most effective and appropriate imaging study. Please see appendix 1 for information on use and function of the CDS. The goal of CDS is for physicians to move away from quantity of tests ordered to focus on quality and appropriateness of testing. We expect to see a reduction in the total charges for patients undergoing imaging studies.

Our planned approach to implementation is:

Phase 1 (Demonstration Year 1):

- Complete 3 process improvement workshops. (value stream mapping and Kaizen workshops)
- Collect/evaluate baseline data
- Establish methodology to document/ report metrics

Phase 2 (Demonstration Years 2-5):

- Identify and implement clinical decision support tool
- Train and certify physicians and staff on Clinical Decision Support too.
- Monitor use to ensure achievement of goals
- Continue to collect outcome data

Phase 3 (Demonstration Year 6) Post-PRIME

- Lean methodologies improve the overall operation of the healthcare system. Through continued improvement in efficiency, we will be able to maintain and sustain improvements.

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

The clinical decision support tool will be consistently applied to all patients regardless of the insurance payer or plan. Current practice (without CDS) does not allow for utilization comparison or outcomes data. The CDS tool will allow for tracking of patterns of individual physicians and comparison of utilization. This will lead to reliable application of medically appropriate criteria for better compliance and will help decrease costs by delivering more consistent and higher quality care.

The CDS tool will be especially useful for Medi-Cal patients, who may be at high risk of intermittent care without an established Primary Care Provider. This is particularly true for emergency department patients or those admitted without an established medical history. The CDS tool will make past medical history and current clinical complaints instantly available, and provide an educated, evidence-based recommendation for an approach to care.

Success would include a reduction in the number of imaging studies, continued improvement in patient outcomes, access to care and reduction in lengths of stay and overall costs associated with the patient visit. Provider education will include information on how to utilize the tool, hospital policies including details if the CDS recommendation is overridden and information on patient education, particularly if patients request particular tests. Overall, imaging services optimized by lean, utilizing CDS, will provide the highest quality, appropriate care at a lower cost.

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

Check, if applicable	Description of Core Components
Applicable	**3.2.1** Implement an imaging management program, demonstrating engagement of patients in the design and implementation of components of the project.
Applicable	**3.2.2** Program should include identification of top imaging tests whose necessity should be assessed for possible overuse. Criteria for assessment could include: • Frequency and cost of inappropriate/unnecessary imaging: o Appropriate Use: Beginning with state- or nationally-recognized models or guidelines (e.g., American College of Radiology Appropriateness Criteria, American College of Cardiology

Check, if applicable	Description of Core Components
	Appropriate Use Criteria) and incorporating pertinent local factors, programs will set out definitions for appropriateness. o Cost: Programs will identify imaging studies associated with high costs due to high cost per study or high volume across the system. • Unwarranted practice variation within the participating DPHs/DMPHs. Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed. • Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed. • Whether there are established, tested and available evidence-based clinical pathways to guide cost-effective imaging choices.
Applicable	**3.2.3** Establish standards of care regarding use of imaging, including: • Costs are high and evidence for clinical effectiveness is highly variable or low. • The imaging service is overused compared to evidence-based appropriateness criteria. Lack of evidence of additional value (benefits to cost) compared to other imaging options available to answer the clinical question.
Applicable	**3.2.4** Incorporate cost information into decision making processes: • Develop recommendations as guidelines for provider-patient shared decision conversations in determining an appropriate treatment plan. • Implementation of decision support, evidence-based guidelines and medical criteria to recommend best course of action.
Applicable	**3.2.5** Provide staff training on project components including implementation of recommendations, and methods for engaging patients in shared decision making as regards to appropriate use of imaging.
Applicable	**3.2.6** Implement a system for continual rapid cycle improvement and performance feedback that includes patients, front line staff and senior leadership.

Please complete the summary chart:

	For DPHs	For DMPHs
Domain 3 Subtotal # of Selected Projects (Select At Least 1):	**1**	**1**
Domain 3 Total # of Projects:	**1**	**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 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 $ 7,640,000
- DY 12 $ 7,640,000
- DY 13 $ 7,640,000
- DY 14 $ 6,876,000
- DY 15 $ 5,844,600

Total 5-year prime plan incentive amount: $ $35,640,600

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.	Implement a Palliative Care Program using a Multidisciplinary, team-based approach.	Go live with inpatient program. Provide a full-time Inpatient Palliative Care Program team including: Medical Director, Nurse Practitioner, Coordinator, Spiritual Care Nurse, and Social Worker.	2.7	Start Date: January, 2016 End Date: Go Live: June 30th 2016
2.	Implement ambulatory palliative care program	• Provide follow up calls for patients requiring outpatient services • Finalize physician space for outpatient palliative care services • Complete policies and procedures to successfully provide outpatient palliative care • Go live with the outpatient program.	2.7	Start Date: July, 2016 End Date: 12/2016
3.	Implement Prenatal Diagnostic Clinic	• Furnish secured PDC space. • Develop a floor plan for the clinic. • Purchase all necessary equipment and supplies • Hire office staff and a nurse • Finalize contract and complete recruitment of perinatologist (In Progress) • Finalize and	2.1	Start Date: 1/2016 End Date: 1/2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		implement policies and procedures in consultation with UCSF • Monitor developed PDC budget.		
4.	Implement lean methodology in the imaging department to improve patient flow.	Launch Imaging Value Stream: • Complete 3 process improvement workshops • Reduce patient wait times • Increase patient access for imaging services.	3.2, 3.26	7/2016-6/2017
5.	Complete Physician and Staff training sessions on clinical decision support tool.	• Conduct and complete training sessions for WHHS physicians, allied health professionals and staff • Certify all WHHS physicians, allied health professionals and staff through the successful completion of a post-test administered after training has been completed.	3.25	2/2017-6/2017
6.	Implement clinical decision support tool	Evaluate options and review tools, select final clinical decision support tool	3.2, 3.23	1/2017-6/2017

Appendix 1: Lean Approach to High Cost Imaging Studies

Clinical Decision Support tools provide a choice or range of imaging procedures as appropriate, based on the medical evidence as identified by the patient's past history such as information from prior exams, patient and family medical history and risk factors, along with clinical expertise and input based on current clinical circumstances. The radiologist or ordering physician then chooses the most appropriate imaging study based on all of the factors including the patient's symptoms and history. All providers and support staff will be trained and certified on the use and function of the CDS. The goal of the CDS is to reduce the quantity of tests in favor of providing appropriate quality tests. In addition, total charges for imaging studies will be reduced. Physicians and staff will be trained on how to utilize the CDS tool. Once implemented, we will track the types of imaging studies and charges associated.

Table 1: Major disparities in the community (from Community Needs Assessment 2013)

	ZIP Code	Mortality	ED Visits	Hospitalization
Diabetes	94538	**2.2**	**271.3**	**186.4**
	94544	**2.3**	**201.7**	160.3
	94560	1.4	**312.6**	**198.5**
	94587	**2.3**	**187.7**	138.1
	Alameda County	*1.9*	*250.8*	*178.5*
	CA State	*1.8*	*188.4*	*190.9*
	Healthy People 2020	*6.6*	--	--

(Sources: Mortality: CDPH, 2010; ED Visits and hospitalization: OSHPD, 2011)

	ZIP Code	Mortality	ED Visits	Hospitalization
Heart Disease	94538	**12.1**	**176.8**	**230.8**
	94544	**11.4**	**188.2**	**304.4**
	94560	**11.8**	**184.8**	**243.1**
	94587	**10.2**	**178.5**	**240.4**
	Alameda County	*9.6*	*133.8*	*213.4*
	CA State	*11.5*	*93.1*	*218.4*
	Healthy People 2020	*10.1*	--	--

(Sources: Mortality: CDPH, 2010; ED Visits and hospitalization: OSHPD, 2011)

	ZIP Code	Mortality	ED Visits	Hospitalization
Stroke	94538	2.7	**24.9**	**54.9**
	94544	3.0	**37.1**	**68.9**
	94560	2.6	**29.0**	**49.3**
	94587	2.9	**32.8**	**53.4**
	Alameda County	*3.6*	*26.7*	*60.4*
	CA State	*3.5*	*16.2*	*51.8*
	Healthy People 2020	*3.4*	--	--

(Sources: Mortality: CDPH, 2010; ED Visits and hospitalization: OSHPD, 2011)

	ZIP Code	ED Visits	Hospitalization
Hypertension	94538	**578.5**	365.5
	94544	**838.8**	**499.0**
	94560	**623.3**	**372.6**
	94587	**616.5**	**375.5**
	Alameda County	*536.3*	*367.8*
	CA State	*365.6*	*380.9*

(Source: OSHPD, 2011)

Table 2: Economic Characteristics by Zip Code – Community Needs Assessment 2013, US. Census Bureau (2010), Department of Labor Statistics (2012)

Zip Code	Unemployment Rate	Median Income	Households Receiving Assistance	Poverty Rate
94536	7.5%	$84,840	9.3%	5.5%
94538	8.0%	$81,408	11.0%	6.3%
94539	6.1%	$138,578	7.7%	3.7%
94544	12.7%	$61,291	21.5%	13.5%
94555	6.0%	$108,791	6.7%	5.9%
94560	8.6%	$81,777	11.5%	6.4%
94586	1.6%	$74,375	4.3%	3.6%
94587	8.0%	$82,634	14.2%	7.7%

	% Households in poverty over 65 headed	% Families in poverty w/ kids	% Families in poverty, female-headed	% over 25 with no high school diploma	% Non-White or Hispanic	% pop over age 5 with limited English	% Unemployed	% No health insurance	% Residents Renting
94538	1.3	4.7	8.1	13.0	71.0	12.3	8.0	10.4	50.3
94544	1.5	14.2	34.2	22.7	82.4	16.1	12.7	15.4	46.5
94560	1.2	7.9	26.1	14.0	71.1	8.9	8.6	9.7	27.8
94587	1.9	7.9	33.9	13.9	86.0	10.8	8.0	10.3	30.6

Table 3: Population Distribution by Age – Community Needs Assessment 2013

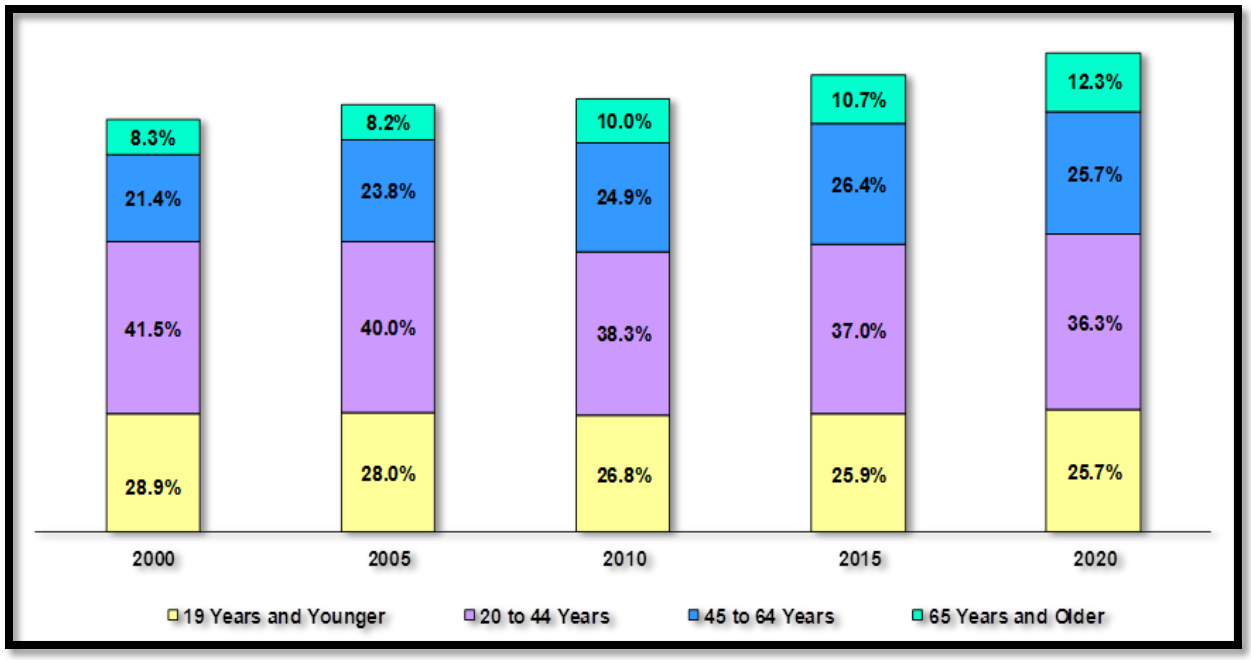


Table 4: Racial and Ethnic Characteristics of Residents Served by Washington Hospital – United States Census 2011

Zip Code	Total Population	Hispanic	White	Black	American Indian	Asian	Pacific Islander
94536	66,617	18.3%	35.4%	4.1%	0.2%	36.9%	0.7%
94538	60,461	26.0%	29.0%	3.6%	0.3%	36.7%	0.6%
94539	51,021	4.2%	21.6%	1.4%	0.0%	68.9%	0.4%
94544	74,499	45.1%	17.6%	9.9%	0.3%	20.1%	3.0%
94555	33,656	7.6%	21.9%	3.3%	0.3%	63.5%	0.8%
94560	42,322	35.2%	28.9%	4.1%	0.0%	25.9%	2.5%
94586	785	15.3%	73.1%	0.0%	0.0%	3.9%	0.0%
94587	68,830	21.5%	14.0%	6.1%	0.2%	53.0%	1.0%
TOTAL	398,191						

Table 5: Socio-demographic Indicators – Community Needs Assessment 2013

Zip Code	Female Headed Family Household	Adults w/out High School Diploma	Veterans	Foreign Born	Non-Citizens	Limited English
94536	9.4%	10.3%	5.9%	37.0%	47.8%	17.4%
94538	12.7%	13.0%	5.2%	41.5%	53.6%	24.3%
94539	6.1%	4.9%	4.2%	48.1%	36.3%	21.3%
94544	17.1%	22.7%	5.8%	38.6%	55.9%	30.4%
94555	6.6%	8.8%	6.1%	50.1%	38.4%	22.5%
94586	6.2%	5.8%	9.0%	16.9%	12.8%	9.2%
94587	12.8%	13.9%	5.4%	46.2%	36.6%	23.6%

Table 6: Payor Mix at Washington Hospital Based on Visits– Based on FY 2016 ER Payor Mix

Payor	IP	OP	Total
HMO	2.9%	4.1%	3.9%
INDUSTRIAL	0.2%	1.9%	1.6%
MEDI-CAL	8.3%	6.8%	7.0%
MEDI-CAL HMO	15.3%	36.7%	33.4%
MEDICARE	47.8%	15.7%	20.6%
MEDICARE HMO	8.6%	2.2%	3.2%
PPO	14.7%	23.8%	22.4%
SELF PAY	2.2%	8.8%	7.8%
Total	**100.0%**	**100.0%**	**100.0%**

Table 7: List of Awards

Quality and Safety Awards

Joint Commission Accreditation

Washington Hospital has earned the prestigious Joint Commission seal of approval. The full three-year accreditation is the Gold Seal of Approval from the nation's oldest and largest standards-setting and accrediting body in health care. (August 2014)

Healthgrades

Washington Hospital is an honored, three-year recipient of the Healthgrades Distinguished Hospital Award for consistently providing comprehensive and clinically excellent care. (2014-2016)

The Healthgrades Patient Safety Excellence Award for 2015 was presented to Washington Hospital for ranking among the top 5% of hospitals in the Nation for Patient Safety. (2015)

Washington Hospital has ranked among the top 5% in the nation for women's health (2014-2015), making it a recipient of the Healthgrades Women's Health Excellence Award for the third consecutive year. (2012-2015)

Best of Fremont Award

Washington Hospital is the recipient of the Best of Fremont Award. (2015)

Baby-Friendly Hospital by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF)

Washington Hospital is one of few U.S. hospitals recognized for exceptional support of breastfeeding moms and babies. (2014)

U.S. News and World Report

U.S. News & World Report has ranked Washington Hospital within the top ten best regional hospitals in the San Francisco Metro Area and the top forty best hospitals in California. Washington Hospital was also recognized by U.S. News & World Report for its high performance in hip and knee replacement surgery. (2015)

U.S. News & World Report has ranked Washington Hospital as the best hospital in the San Francisco Metro Region in 7 specialty areas. Washington Hospital was recognized for its high performance in nine specialties including gastroenterology and GI surgery, geriatrics, gynecology, nephrology, neurology and neurosurgery, orthopedics, and urology. Washington Hospital also scored high in patient safety, demonstrating commitment to reducing accidents and medical mistakes. (2014)

Alameda County EMS “Professional Partner” Award

Washington Hospital, a designated cardiac receiving center for Alameda County, received a “Professional Partner” award from the Alameda County Health Care Services Agency for the Emergency Department’s teamwork in administering life-saving intervention to a cardiac arrest patient. (2013)

Quest for Zero Award in ED

Washington Hospital has been recognized by Beta Healthcare Group for its Quest for Zero quality initiative in the Emergency Department. Quest for Zero is a risk reduction program to improve patient safety. Washington Hospital earned the award when 100% of the Emergency Department nurses and physicians completed Tier I & Tier 2 of the Quest for Zero initiative. (2012, 2013)

Quest for Zero Award in OB

Washington Hospital has been recognized by Beta Healthcare Group for its Quest for Zero quality initiative in Obstetrics. Quest for Zero is a risk reduction program to improve patient safety. (2013, 2014)

Magnet® Status by the American Nurses Credentialing Center

The American Nurses Credentialing Center has recognized the high level of care that Washington Hospital’s nurses provide to patients and families. The Magnet Status designated is for a four-year period. Work is currently underway to extend Magnet designation for another four years. (2011)

Table 8: External Quality Databases and Registries where Washington Hospital Participates

Collaborative Alliance for Nursing Outcomes, National Database for Nursing Quality Indicators, National Healthcare Safety Network, the Joint Commission, Society for Thoracic Surgeons, American College of Cardiology and National Surgical Quality Improvement Program, Get With the Guidelines American Stroke Association, California CABG Outcomes Reporting Program

Table 9: Ethnic Distribution of Washington Hospital Nursing Staff Compared to Primary Community Served (Fremont, Union City, Newark) – United States Census Bureau Community Needs Assessment and National Database for Nursing Quality Indicators (2013)

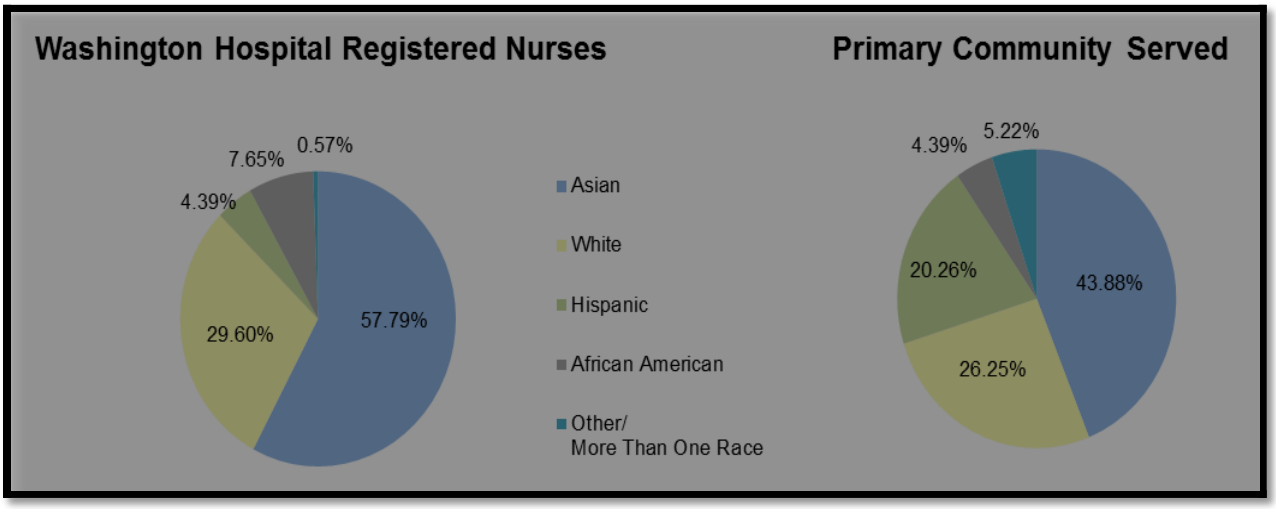


Table 10: Payor Mix at Washington Hospital Based on Visits– Based on FY 2016 (As of March 2016) Inpatient and Outpatient Payor Mix

PAYOR MIX	IP Cases	OP Cases	Total Cases	Inpatient%	Outpatient%	Total%
Commercial	95	676	771	0.91%	0.84%	0.84%
HMO	541	2,219	2,760	5.16%	2.74%	3.02%
Legal	1	206	207	0.01%	0.25%	0.23%
Medi-Cal	616	2,556	3,172	5.88%	3.16%	3.47%
Medi-Cal HMO	1,166	14,923	16,089	11.12%	18.44%	17.60%
Medicare	3,823	28,129	31,952	36.47%	34.76%	34.96%
Medicare HMO	569	2,062	2,631	5.43%	2.55%	2.88%
Out of Country	7	57	64	0.07%	0.07%	0.07%
PPO	3,492	25,317	28,809	33.31%	31.29%	31.52%
Self-pay	71	3,258	3,329	0.68%	4.03%	3.64%
Travelers Out of Country	29	38	67	0.28%	0.05%	0.07%

Tricare	20	342	362	0.19%	0.42%	0.40%
Worker's Comp	54	1,129	1,183	0.52%	1.40%	1.29%
Total Cases FY16 Mar YTD	**10,484**	**80,912**	**91,396**	100.00%	100.00%	100.00%

Table 11: **Job Description and Role of the Dedicated PRIME Manager**

A dedicated PRIME Program Manager will be responsible for monthly tracking of all metrics, analysis and evaluation of efforts. The following will be responsibilities of the PRIME manager:

-Oversight of teams

-Monthly tracking of metrics, development of dashboard

-Identification of challenges ahead of time and during implementation (risk analysis)

-Analysis of metrics and evaluation of efforts

-Update of the dashboard on a monthly basis

-Communication of results to clinical and non-clinical staff involved

-Reporting of results to the executive team

Table 12: **Detailed Description of Services Provided by the Perinatal Diagnostic Clinic**

Scope of services of the PDC includes: amniocentesis, diagnostic ultrasound, and genetic testing and counseling. Fetal echocardiogram and fetal brain MRI can also be done in San Francisco, if necessary, through our partnership with UCSF.

More specifically:

Service Model for Screening

- First trimester blood work will be ordered by referring clinic at 10 ½ weeks (done with routine prenatal labs). Patient will be coached to have lab drawn about 1 week prior to scheduled NT ultrasound in order to be able to receive an instant result
- Patient or provider will refer patient to PDC to schedule NT ultrasound
- PDC staff will communicate with Prenatal Screening Lab to gain access to patient lab entry, and will calculate first trimester aneuploidy risk:
  - ✓ If biochemistry is processed and available, patient will receive instant result at the conclusion of her ultrasound visit, with a face to face discussion with a genetic counselor. Counselor will provide interpretation of result, and prenatal diagnosis will be discussed depending on value of risk and specific preference of patient

- ✓ If biochemistry is not available, the patient will be contacted by phone with the result, by a genetic counselor, as it is available. A separate summary note documenting phone communication will be generated.

- Second trimester screening will be ordered by the referring clinician at 15-18 weeks
- Second trimester or Integrated results will be obtained by PDC from State Screening Program when patient is seen in PDC for second trimester ultrasound
  - ✓ Specific result will be discussed with the patient by the clinician at the time of her ultrasound, with interpretive analysis of serum marker values and any associated risk for adverse outcome (increased surveillance recommended and documented in summary letter)
  - ✓ Depending on actual value of aneuploidy risk and in the context of any ultrasound findings, patient may be offered prenatal diagnosis.

Communication of results

- Abnormal ultrasound findings will be discussed with the patient at the point of service and called to the referring practice on the same day
  - ✓ If the referring provider's office is closed when the anomaly is identified, a message will be left, if possible. Alternatively, the practice will be contacted on the next business day
- All procedure notes will be finalized on the day of service and electronically transmitted or faxed to the referring provider at the end of the business day
- If a maternal indication or ultrasound finding suggest any follow-up studies, we will schedule follow up appointments and notify the referring provider to request a requisition or order prior to the scheduled appointment
  - ✓ If it is necessary that the study be coordinated by the referring provider (based on specific insurance for example), this will be clearly communicated in the summary note
- Perinatal consult summaries and notes summarizing multiple studies (fetal echocardiogram, fetal brain MRI (which would be performed in San Francisco), will be sent to the referring provider as soon as finalized
  - ✓ Abnormal findings will be discussed with the patient at the point of service and called to the referring practice on the same day
- Cytogenetic and/or molecular results will be communicated to the patient by phone, by a genetic counselor, as soon as they are released.
  - ✓ Abnormal findings communicated to the referring provider by phone and/or electronically transmitted/ or fax on the day they are released.
  - ✓ All patients with an abnormal result offered in person consultation with a Prenatal Clinical Geneticist.
  - ✓ Summary notes with cytogenetic and/or molecular studies mailed to the practice once reviewed and signed by PDC prenatal clinical geneticist

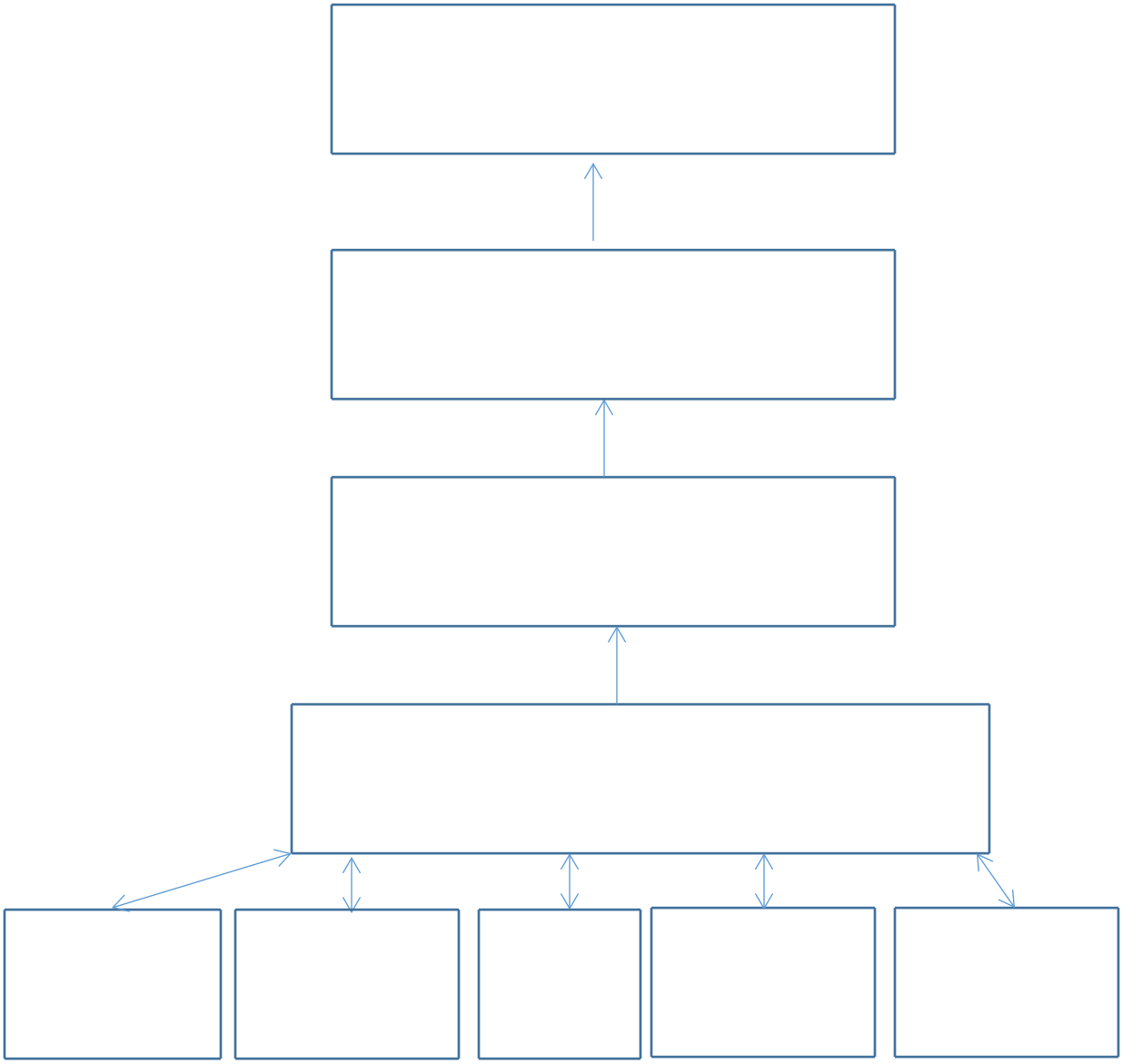
Table 13: Planned Activities, Roles and Responsibilities of Comprehensive Approach taken by the Palliative Care Team

Palliative Care Team Member	Role and Responsibilities
Nurse Practitioner	Intake, assessment, ordering medication and treatment, follow up of patients and holds team together
Coordinator	Patient rounding, coordinates patient-family conferences, facilitates communication within the team
Spiritual Care Nurse	Focuses on spiritual healing and counseling, rounds on patients daily
Business Assistant	Maintains records, orders supplies, collects data, handles staffing/scheduling/time cards, other administrative duties
Medical Directors	Oversees nurse practitioner orders for medication and treatments, provides medical perspective and
Social Worker	Provides for community resources and social work needs of patients and families during their stay and at discharge
Administrator	Executive sponsor to help navigate the program

Table 14: Capacity of involvement of interdisciplinary departments in management of PRIME and reporting structure for PRIME

Department	Capacity of Involvement
Quality and Resource Management (Quality and Resource Management Committee; Quality Management Team)	• Assist professional staff in the development of an effective monitoring and evaluation system, a quality assessment and performance improvement program, and the use of performance improvement tools like Failure Modes and Effect Analysis (FMEA), quality

Department	Capacity of Involvement
	improvement techniques, and use of statistical control processes. • Provide for the integration and coordination of data utilizing automated data sources when available, as well as traditional sources of information. • Provide educational and resource information related to quality outcomes management and /or performance improvement.
Nursing	• Continuously assessing and improving the performance of care and services provided. • Recommending a sufficient number of qualified and competent persons to provide care, including treatment. • Developing and implementing policies and procedures that guide and support the provision of services.
Physicians (Medical Executive Committee)	• Will receive and take action on reports • Review metrics and approve performance plans
Strategic Management	• Recommending space and other resources needed by the department. • Participating in the selection of sources for services not provided by the department or the organization.
Finance	Oversight of budget and Prime Project Manager.



Reference:

1. Washington Hospital Healthcare System Health Service Area, Community Health Needs Assessment. Valley Vision, Inc. Aug 2013.
2. Temel J et al, Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer. NEJM, 2010
3. Greer JA, et al, Effect of Early Palliative Care on Chemotherapy Use and End of Life Care in Patients with Metastatic Non-Small Cell Lung Cancer. J Clin Oncol 2012;30:394-400
4. CAPC Palliative Care Registry 2012 Annual Survey Summary https://registry.capc.org/cms/Reports.aspx
5. Washington Hospital Cyracom International (translational services) data. 2011
6. Hospital Compare, https://www.medicare.gov/hospitalcompare/search.html (Accessed: 3/18/2015)
7. Lehnert BE, Bree RL. Analysis of appropriateness of outpatient CT and MRI referred from primary care clinics at an academic medical center: How critical is the need for improved decision support? Am Coll Radiol. 2010
8. Best Practice Guidelines on Imaging Clinical Decision Support Systems, American College of Radiology 2012