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**

Kern Valley Healthcare District

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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 the 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	Kern Valley Healthcare District
Health Care System Designation	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 review of the 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.

Kern Valley Healthcare District (KVHD) was created in 1964 by the board of supervisors of Kern County, California, following a vote of the registered voters of the proposed District. KVHD includes approximately 400 square miles located within the northeastern quadrant of Kern County, California, with a year-round population of approximately 15,000 residents.

Physical Health. The most significant health issues facing our community include heart disease, obesity/diabetes, and pulmonary disease:

- *Pulmonary:* More than 6.39% of the patients transferred from the emergency room are for pulmonary disease. COPD is the 11th most prominent diagnosis in Kern County and Simple Pneumonia with complications is the number one admission diagnosis for KVHD.
- *Obesity/Diabetes:* More than 20% of county residents are obese. This epidemic contributes to the high incidence of diabetes creating hypertension and circulatory disorders which is the 10th most prominent diagnosis in Kern County and number 1 ranking for outpatients in the Lake Isabella area. Twenty-eight percent of the adults in Kern County have a BMI index greater than or equal to 30.
- *Heart Disease:* Although Heart Failure and Shock has the number 12 ranking for Kern County, it ranks number 6 for the Lake Isabella area.

Behavioral Health. Behavioral health issues are also a challenge for Kern County. The diagnosis of Psychoses is the third most prevalent diagnosis for Kern County after Normal newborn and Vaginal Delivery without complications. For the Lake Isabella area, Depression is the second highest diagnosis being treated and although it is treated almost

exclusively by telehealth providers, comprises 15.7% of all of the clinic visits of KVHD.

Health Disparities. Health disparities in Kern County and specifically in Lake Isabella is mainly substance abuse of both prescription and illegal drugs as well as alcohol. Income levels also contribute to health disparities in the County. The median household income in Kern County is $42,727 vs. $61,400 for California. Also, the unemployment rate in Kern County is 11.4% vs. 7.8% in California. Additionally, the teen birth rate in Kern County per 1,000 population ages 15 – 19 is 63 vs. 36 in California.

Coverage. Kern County is host to 874,600 people of whom 24.5% live in poverty. The rate of poverty (i.e., persons living below the poverty line) gradually dropped from 21.3% in 1960 to 12.6% in 1980. However, it climbed gradually to reach 22.5% in 2010 and 24.5% in 2014. Children are most vulnerable to this poverty. Of children younger than 6 years, 35% are poor, of those between 6 and 11 years, 33.5% are needy; and 28.3% of children aged 1 to 17 years live in poverty. The elderly are also vulnerable to poverty. While poverty reached its lowest rate of 15.4% for individuals 45 to 64 years, it rises to 21.1% for those 65 years and older.

The Lake Isabella area is unusually sensitive to the health issues affecting the elderly. With the percent of elderly in the United States at 12.8%, in California at 10.9% and in Kern County at 9.4%, the Lake Isabella area has a population of elderly over 65 years of age of 31.0%.

It is our intent to use the opportunity to participate in PRIME to address the bulk of the aforementioned issues and sensitivities.

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 Kern Valley Healthcare District serves the Lake Isabella population base of 19,694 in 2015, up from 18,440 in 2010. The area is comprised of the following communities and populations: Onyx at 414, Havilah/Caliente at 1,047, Kernville at 1,285, Bodfish at 2,545, Weldon at 2,920, Wofford Heights at 4,550 and Lake Isabella/Mt. Mesa at 6,933.

Income. The average per capita income in Kern County, including all workers full-time and less-than-full-time, is $24,700 per year and the median household income is $48,600. The median household income varies with age. It averages $30,500 for householders younger than 25 years of age, $44,000 for those between 25 and 44 years, $58,200 for heads of household 45 to 64 years, and $43,800 for 65 years and older.

Race/Ethnicity and Language. The population of Kern County has a racial composition of

83% White, 6% African-American, 5% Asian-American, 3% American-Indian, and 3% two or more races. The ethnic composition of County residents includes 50% Hispanic/Latino, 38% White (non-Hispanic/Latino), and 12% others. About 21% of the residents of Kern County are foreign-born, of whom 81% were born in Latin America. Of the foreign-born population, 31% are naturalized citizens and 69% are not citizens. Among County residents, 58% speak English at home, 38% converse in Spanish, and 4% communicate in other languages.

Age. The closest larger population base to the Lake Isabella area is the City of Bakersfield located about 50 miles to the West down a steep canyon road. Bakersfield has a population of 377,600 growing 2.8% per year. Nearly 49% of the Kern County residents are female and 51% are male. With a median age of 31 years, the County has a relatively young population. On the other hand, the Lake Isabella area has a population base of 31.0% that are over 65 years old.

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.

The Kern Valley Healthcare District (KVHD) is a full-service general acute care district hospital. We provide ICU, swing-bed, acute, outpatient, and emergency care at the 25-bed critical-access Hospital as well as provide 74 beds of skilled nursing care (SNF), a hospital-based rural health clinic and a District owned retail pharmacy serving the public as well as the nursing home. Of our 101 beds, we have 3 intensive care beds, 24 acute/swing-beds, and 74 skilled nursing beds.

The acute care general hospital currently runs 40% Medicare, 6% Medi-Cal, 6% Commercial Insurance, 21% Managed Care Medicare, 24% Managed Care Medi-Cal, 1% Managed Care and 2% Self-pay. The emergency room financial class mix is 20.0% Medicare, 5.2% Medi-Cal, 9.1% Commercial Insurance, 12.8% Medicare Managed Care, 42.1% Medi-Cal Managed Care, 4.6% Managed Care and 6.2% Self-pay. The skilled nursing unit is 87% Medi-Cal, 7% Insurance/Hospice, 3% Managed Care and 3% Self-pay.

The Hospital and Skilled Nursing Unit are the only services of this type within a 50 mile radius and virtually most service disciplines are provided, although some of those services are provided by telemedicine like the stroke unit that is remotely staffed by board certified neurologists on a 24-7 coverage basis.

The fiscal year-to-date acute average daily census is 4.9 and for swing beds is 2.6. The average daily census in the SNF is 70.5. The emergency department averages 600 visits per month, the primary care clinic 1,148 and the specialty clinic 279 visits per month, and referred outpatients for ancillary services are 1,021 per month. There is an average of 4 surgeries and 44 endoscopies performed per month. Finally, the retail pharmacy averages 3,548 prescriptions issued per month.

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.

Heretofore, Kern Valley has been using the Evident module from CPSI electronic medical records system that was installed at the District for both clinical and financial reporting in FY 12. Given that we are now poised to embark on this PRIME project and meet the reporting requirements, KVHD has initiated a review and order for the Quantros quality and risk reporting initiative to streamline the approach to analytics. KVHD is very interested in tracking wellness and integrating the quality reporting initiatives necessary to meet the PRIME project requirements.

Data Collection. We have recently modified the measures that we report internally and externally. KVHD reduced duplication or measures that had already met the target and benchmark and identified new and valued critical measures which are linked with either performance improvement initiatives, strategic goals, or material cost savings.

Reporting. The KVHD quality assurance coordinator developed a range of dashboards to track performance. For example, our utilization, clinical performance and satisfaction dashboards are reported to administration, medical staff and the Board on a monthly basis and both positive and negative variances from the target and/or benchmark are discussed and a work plan developed for continuance or correction as appropriate.

Monitoring. Our analytics team reviews data collection processes and outcomes on an on-going basis. The team is comprised of both administrative, medical staff, nursing and financial stakeholders to capture the broad perspectives in an effort to improve both the organization and patient care as well as foster patient satisfaction.

Barriers. The significant barriers to meeting the PRIME reporting requirements is the size of our quality department, the acquisition of the Quantros quality and risk reporting software and the time availability of clinical staff with a focus on the PRIME project in the patient care areas for both the Hospital and the Rural Health Clinic. We anticipate an additional FTE will be necessary in the quality department as well as in the Clinic. The Quantros quality and risk reporting software is currently being scheduled for installation. A first year down payment of $7,000 has been made toward the annual cost of the software of $19,000. We believe that with the addition of this software tool, we will have the capability to capture and analyze meaningful information to the improvement of patient and provider satisfaction and improved patient outcomes. Also, we anticipate the hiring of an additional employee in the quality assurance department. This additional employee needs to be conversant with healthcare norms as well as clinical applications

and their use and manipulation. It is anticipated that this employee addition plus 30% benefits will cost the District some $32,500 per year plus a consumer price escalator.

Section 3: Executive Summary

The objective of PRIME is to accelerate participating entities' efforts (as applicable), to change care delivery and to maximize health care value and strengthen the ability to successfully perform under risk-based Alternative Payment Methodologies (APMs). This section of the Plan will be used to review each entity's overall goals and objectives. 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.*

   Because we have such a high population base of elderly, obese and addictive patients and potential patients in the Lake Isabella area, KVHD's goal is to improve the health of our patients by integrating the physical and behavioral health services that we can and do provide. We are moving toward a population health management model that expands the available services to support our transition toward APMs and value-based payments.

   As part of PRIME, KVHD intends to implement more alternatives and focus to guide patients and their families through a synergistic approach to patient care through incorporating both physical and behavioral health services, including a focus on improved care management and care transitions to reduce avoidable utilization and provide less discomfort to the patient. This will support delivery system transformation in that KVHD will be better able to provide whole-person care in the setting that is best suited to the patient's clinical and social needs.

2. *List specific aims** for your work in PRIME that relate to achieving the stated goals;*
   Note:
   ** *Specific aims (generally 2-5) relate to the goals but provide more detail on how the goals will be achieved.*

   We have three overarching specific aims for KVHD's PRIME participation: (1) to integrate a behavioral health model into our inpatient acute/swing care; (2) to implement case conferences/consults on patients with complex needs and (3)

demonstrate patient engagement in the design and implementation of the project.

The first of the three overarching specific aims for the KVHD PRIME participation is “to integrate a behavioral health model into our inpatient acute/swing care.” Some specifics in this regard is that the medical director of our behavioral health services has, and is developing integrated physical and behavioral inpatient healthcare services in numerous medium-sized hospitals in California. We believe that this can work well in small hospitals as well. Kern Valley has the added bonus of having 16 licensed swing beds where the physical acuity is less, but the patient still receives the same nursing care as do the acute care patients. We believe that these swing beds are a tailor-made environment to implement this integrated program.

In terms of behavioral health, we will:
• More consistently identify behavioral health needs through routine use of screening tools (e.g., PHQ-2, SBIRT) in inpatient and outpatient settings;
• Identify additional behavioral health resources or additional hours of service from the existing resources, including resolving space constraints for outpatient clinic services,
• Connect patients to needed services through telemedicine vehicles.

The second of the three overarching aims for the KVHD PRIME participation is “to implement case conferences/consults on the patients with complex needs.” Currently, if a patient in an acute care or even a swing bed from complex physician needs, the plan of care is normally only addressed by both physicians and nurses for the physical needs and the behavioral needs are only addressed after the patient is transferred to a skilled setting or behavioral consultation is added to the care plan. KVHD believes that a multi-disciplinary care plan development and on-going update should ensue from admission or inception where behavioral health issues are obviously present.

The third of the three overarching aims for the KVHD PRIME participation is “to demonstrate patient engagement in the design and implementation of the project.” It is the intention of KVHD to ask the inpatient behavioral health medical director to evaluate and recommend past, existing or present patients to be involved in the PRIME Advisory Committee (PAC) team at KVHD that can bring value to the table through actual experience or knowledge and help develop the design and implementation of this integrated program.

KVHD plans to use the Quantros quality software application to do a query each month for dual diagnosis patients in the acute, swing and skilled nursing venues. Since currently our dual diagnosis patients are not tracked on this basis, the monthly values will be trended by quantity and then graphed. In addition, benchmarks will be obtained as available regarding the percentage of dual – diagnosis patients to total patients and any performance improvement of utilization of PAC teams, PRIME type projects or patient screening techniques. These benchmarks will be compared to the KVHD data query results and a variance

analysis report will be developed, tracked and graphed. Both the trend analysis and the variance analysis information will be reported monthly to the PAC team and the Medical Quality Counsel which will carry forward to Board approval of developed action plans to address both positive and negative variances to be used in the development of policies and procedures as they prove their quality of care worth over time.

In addition to the individual development of a monitoring system for TVHD's PRIME project, the District is a member of the California District Hospital Leadership Forum (DHLF). DHLF is currently evaluating a project with CAPH and its Safety Net institute to have NCQA manage the PRIME metrics specifications. The purpose of this project is to provide support to CAPH/SNI in the development and implementation of the PRIME measures, building off the considerable experience NCQA has as a measure developer and steward. NCQA will work with CAPH/SHI staff to perform testing and analysis of new, innovative performance measures, modify existing nationally endorsed performance measures for the PHS environment, provide technical assistance as the measures are implemented and develop an audit program to ensure the data are reliable and comparable. This will allow CAPH/SNI the confidence that the metrics utilized in PRIME are rigorously tested and can reliably report on the quality of health care for California's public health care systems.

We are also committed to maintain a single shared EHR/medical record that is accessible across the treatment venues and providers to ensure coordination of care planning.

KVHD anticipates that expanding behavioral health services and other targeted clinical outcomes and reducing the incidence of avoidable return visits will ultimately improve care delivery and the patient experience for a much broader percentage of our patient population.

3. *A statement of how the selected projects will support the identified organizational goals and project aims. Note that the narrative should connect the aims identified in Section 3.1.2 to the projects you select in Section 4. Each project does not require a separate aim statement;*

KVHD selected the integration of primary care and behavioral health (Project 4.1.1). This selection directly corresponds to our project aims and will enable us to develop the infrastructure needed to integrate behavioral and physical health services.

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,*

Only one project is selected.

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

At the end of the five years, patients served by KVHD will receive the right clinical and support services, when they need them, and in the care setting that is optimal for their needs at that time. We will have the infrastructure and staff to identify co-occurring physical and behavioral health needs and will provide seamless connections to services across the system.

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. The narrative should clearly link the projects you select in Section 4 with the community needs identified in your response to Section 2.1.

Behavioral health data regarding our community, as described in our response to Section 2.1, underscores the rationale to focus on behavioral health and those community demographics that support a need to change behavior. Specifically, enhancing our ability to identify behavioral health conditions among our patients and develop standardized processes and measurements to connect patients to treatment. We believe this will improve our ability to provide whole-person care in a timely manner. It will also decrease the amount of mental health and substance abuse disorders that go unacknowledged and untreated. Since many patients have co-occurring physical and behavioral health diagnoses, ensuring that behavioral health needs are identified and addressed and timely treated should also impact our ability to improve health outcomes.

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).

KVHD's governance strategy is rooted in our commitment to the communities and patients we serve. As a district hospital, our board members are individually- elected public officials. Board members are very knowledgeable about both the health care needs of our community and the need to reduce unnecessary utilization. One of these Board members is a practicing hospitalist physician and another is a retired respiratory therapist. They are also committed to robust engagement and oversight of PRIME-related activities.

KVHD believes that the goal of the integration of physical and behavioral health services is the prime basis for the community, in that as many as 15% of all of our acute care inpatients have a complication or co-morbidity of ETOH use/withdrawal, and the associated physical health conditions and complications that come with that dual diagnosis. In addition, 83.26% or our inpatients come through the emergency room rather than direct admission from their primary care provider. Also, of the emergency room visits, 42.10% are Medi-Cal managed care and another 5.22% are straight Medi-Cal, as well as 6.11% private pay which financial classes contribute to the percentage of dual diagnosis patients being higher than in other venues. KVHD believes that dual diagnosis patients are the major users of emergency and inpatient care in our local community.

If approved, KVHD will establish a PRIME Advisory Committee (PAC) to begin planning for participation in and on-going review of the new program. It is anticipated that initially the members of the PAC team will be:
1) The hospitalist physician who is a member of the District Board.
2) The behavioral health medical director, or his appointee.
3) The Chief Executive Officer of the District organization.
4) The Chief Nursing Officer of the District organization.
5) The Director of Nursing of the long-term care unit of the District.
6) The licensed clinical social worker or medical social worker of the District.
7) A member of the Kern County PET Team assigned to the Lake Isabella area. 8) A user or service member of the local community.
9) A member of the behavioral health collaborative for Kern County.

The PAC's charter will be to: guide the development of the KVHD PRIME plan; recommend to the Board necessary infrastructure investments; and monitor progress toward KVHD's efforts to meet its PRIME goals and performance standards. We expect the PAC to convene at least monthly in 2016 during the implementation phase. The PAC will, at a minimum, provide meeting minutes to the Board in advance of each Board Meeting and will respond to ad hoc inquiries.

The staffing of the PRIME project will be done with the addition of one FTE in the Quality Assurance department. It is also anticipated that we will need a coordinator for the project in the inpatient side of the business. This would be an addition to the Utilization Review (U/R) department of the Hospital by a knowledgeable individual in utilization review to assist the existing staff. Since the majority of the employee staff at the Kern Hospital have backgrounds only in physical medicine, KVHD plans to have this U/R addition by either a Licensed Psych Tech or a nurse with experience in mental health units. KVHD expects to spend about $39,000 including benefits per year for this employee plus annual escalators.

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.

KVHD will ensure that stakeholders and beneficiaries have multiple opportunities to be engaged in PRIME planning and implementation. This will be accomplished in several ways. First, the PAC will include a seat for a health care consumer representative. The consumer representative will serve as a voting member of the Committee. We will also provide an opportunity for questions and comments from the public during all Board Meetings in order to ensure that consumers have an opportunity to provide substantive input and feedback into PRIME-related planning.

We will also establish and augment our relationships with the telemedicine based providers that provide direct patient care services to our patients. We will continue to work with these providers as part of PRIME planning and implementation and will identify additional providers that we may add to these planning activities.

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

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

KVHD has a history of implementing approaches to meet the needs of our elderly and unemployed population. This includes working to ensure that providers, staff and programs reflect the diversity of our patients and that all of our patients have access to health information in their language of choice. We intend to continue these activities as part of our commitment to providing culturally competent service and care.

To support these efforts, we will continue to translate educational materials into our identified threshold languages and provide real-time access to interpreter services as a complement to our provider's language capabilities. In addition, we intend to build on our existing outreach program to proactively engage our community in these efforts. Planned events include twice-yearly health fairs, an annual heart walk sponsored by the Hospital Foundation and further development of additional provider and staff trainings and on-line training programs on issues related to cultural competence and health disparities.

3.6 Sustainability. [No more than 150 words]

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

KVHD has participated in several Lean initiative programs through the California

Critical Access Hospital Network and the University of Southern California in a collaborative effort to improve performance, patient care, and the patient experience. As a result of this work, along with other quality improvement strategies, KVHD will leverage its experience to sustain PRIME improvements through use of the following:

- Engaging providers and staff in planning and implementation, including the use of clinical and non-clinical champions.
- Providing intensive education and training, beginning with a process to identify gaps in knowledge and skills and then developing varied learning opportunities to address these gaps.
- Ensuring senior leadership support for designing and executing strategies related to PRIME implementation.
- Relying on data-driven decision making, including the use of process, outcome and balancing measures.

Section 4: Project Selection

Section 4.1 -- Domain 1: Outpatient Delivery System Transformation and Prevention

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

KVHD selected this project because of the significant need to provide inpatient and expanded behavioral health services to our patients and because we lack the space and infrastructure to routinely identify these needs. Because of the prevalence of behavioral health needs in our county, as described in Section 2, a large number of our patients have co-occurring physical and behavioral health care needs. As a result, improving focus and management of these conditions could also improve health outcomes overall.

Our planned implementation approach includes:

- *Referral Processes:* KVHD will identify telemedicine-based mental health and substance abuse resources and develop and maintain clinic and inpatient programs available across the District's various services. We will conduct outreach as part of improved referral processes, identify gaps in available services, and then develop strategies to address those gaps. We expect to complete this task in demonstration year (DY) 11, however we will continue outreach and development throughout PRIME.

- *Clinical Pathways:* We will convene a task force to review current clinical workflow around mental health and substance abuse screening across settings (ED, acute inpatient, clinic and SNF). The task force will develop common clinical

pathways, reflecting consistent use of PHQ-2 and SBIRT screenings and transfers for referrals (if necessary and available). We expect to begin convening the task force in DY 11 and this work will continue into DY 13.

- *Care Team Training*: KVHD will hire a care coordinator and a quality coordinator, assess the level of education across the care team (e.g., provider, care coordinator, quality coordinator, etc.) regarding behavioral health screening, direct care, and referral processes, as well as patient self-management. We will develop a training program designed to address each of these elements. We expect to begin this work in DY 11 with a needs assessment. Work in DY 12 will include the design of training program and we will conduct trainings in DY 13 and 14.

Primary care physical medicine services would be provided on a face-to-face basis. Specialist physical medicine services would be provided on both a face-to-face and a telemedicine basis depending on the overall volume of patients needing that specialty service, the availability of specialist physicians that are willing to travel to a rural location, and the acuity of the specific case itself and its plan of care. Behavioral care service would virtually all be provided through telemedicine except the nursing, some social services, physical and occupational therapy and activities therapy.

The development of the treatment plan will come through the integration of the multi-disciplinary care team that will include behavioral health providers as well as those from the physical health side. Initially, the care plan development will likely follow the current work flow and independent care plans will be developed by the two disciplines. KVHD believes that the important improvement aspect will be to require the integration of these two care plans into a single masterplan to be used in providing care for the patient and updating the care plan itself.

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

Target Population. Because of the range of interventions associated with this project, we have identified several target populations. For PHQ-2 and SBIRT screenings, we expect the target population to include our elderly patients, and substance dependent patients. We intend to begin this work in one care setting (e.g., the rural health clinic) and then move to other setting(s) (e.g., ED and acute inpatient). For connecting patients to services, we anticipate that the target population for admission to KVHD will be a subset of those who have a positive behavioral health needs screen by telemedicine and can be treated for on-going service by telemedicine. This is because we believe many patients may not need or want referrals (i.e., a patient who has mild depression may continue to see their PCP and even a patient with psychoses can be seen by one of our telepsych physicians).

KVHD is willing to expand the target population for SBIRT screenings through a series of community health fairs. If this no-cost screening does not reach enough of the broader target population, other marketing opportunities will be explored by the PAC Committee. In addition, KVHD plans to work with the Kern Country behavioral health collaborative to reach out to other individual and group practices in the area to do SBIRT screenings. KVHD understands that these provider groups expect some remuneration for their screening services, so we are anticipating putting approximately $300,000 into the PRIME project operating budget to cover these screening services.

Vision for Care Delivery. PRIME will enable KVHD to accomplish several key objectives that are central to our ability to provide high-quality, patient centered care. First, routine screenings for inpatient service will enable us to ensure that we assess needs beyond just physical health. The development of common dual-track clinical pathways for physical and behavioral health will better treat the whole patient.
Identifying telepsych resources will help us connect our patients to care and services beyond the four walls of our health system. This is particularly important because KVHD does not currently have sufficient capacity to meet all of our patient's behavioral health needs in either the clinic or inpatient setting. Providing training to the Care Team related to the importance of behavioral health screening and patient treatment will contribute to improved population management and reduced fragmentation of care for patients.

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

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

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

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

Please complete the summary chart:

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

Section 5: Project Metrics and Reporting Requirements

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

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

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

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

Section 6: Data Integrity

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

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

Section 7: Learning Collaborative Participation

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

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

Section 8: Program Incentive Payment Amount

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

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

- DY 11 $ 1,500,000
- DY 12 $ 1,500,000
- DY 13 $ 1,500,000
- DY 14 $ 1,350,000
- DY 15 $ 1,147,500

Total 5-year prime plan incentive amount: $ 6,997,500

Section 9: Health Plan Contract (DPHs Only)

DPHs are required to commit to contracting with at least one Medi-Cal managed care health plan (MCP) in the MCP service area that they operate using alternative payment methodologies (APMs) by January 1, 2018.

☐ I understand and accept the responsibility to contract with at least one MCP in the service area that my DPH operates no later than January 1, 2018 using an APM.

Section 10: Certification

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

Appendix Infrastructure Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End
1.	Development of a uniform care plan which includes a behavioral health module to be used through all service areas, including acute inpatients.	• The infrastructure-building process will be developed by giving the behavioral health providers admitting privileges in both the acute care and long-term care units. In addition, those psychiatrists providing outpatient services through telemedicine are being requested to enroll in CAQH which will allow them to become a provider under the Mental Health Network. In the past, third-party payers created separate contracts for behavioral health providers and would not allow those services under the physical health contracts. With the advent of the Affordable Care Act and its requirements to treat behavioral health illnesses on the same basis and with similar service coverage as with physical health illnesses, many of the health plans are modifying their position to accept this dual-tract care for dual-diagnosis patients. • Convene a workgroup to review the literature. • Developing a behavioral health integration assessment tool • Work internally to expand the existing program to the acute inpatient services – On the inpatient side, KVHD is looking to meet SB1953 seismic requirements plus improve the existing facilities, not to add more inpatient beds, but to make them more patient friendly and usable for this PRIME project application. Architectural plans have been developed and the current estimates are that the expansion project will require about $44 million to construct. • Pilot the expansion plan – KVHD faces a barrier in infrastructure development related to space requirements both on an inpatient and outpatient basis in which to house any additional patient contingent that may be a result of the PRIME project. There is currently in plan check with Kern County, architectural plans to expand the rural health clinic by four additional exam rooms. Estimates are that the cost of this expansion when finished will be roughly $250,000 plus the associated fixed costs which are estimated to be at around 20%. • Collaborate on evidence based standards of care	1.1	*July 2016-Dec 2016*

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End
2.	Ensure that the treatment plan can be used and updated throughout the continuum of care in the organization .	• Convene a workgroup with expertise in behavioral health integration into physical medicine (i.e., to conduct a needs assessment, research best practices, make recommendations on an approach) • Integrate multiple populations into treatment plan (e.g., obesity, diabetes, end-of-life care, chronic pain management)	1.1	*Jan 2017- June 2017*
3.	Ensure that treatment plan includes behavioral, medical, substance abuse, social and cultural and linguistic needs	• Incorporate traditional medical interventions • Hire a 1 clinical and 1 quality care coordinator • Assess current resources and space • Develop a process to screen new non-traditional options (i.e., gym, nutrition monitoring, wellness, etc.)	1.1	July 2017- Dec 2017