# 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**

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## General Instructions

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

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

### Scoring

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

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

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

## Section 1: PRIME Participating Entity Information

**Health Care System/Hospital Name**

Southern Inyo Healthcare District

**Health Care System Designation (DPH or DMPH)**

DMPH

## Section 2: Organizational and Community Landscape

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

### 2.1 Community Background. *[No more than 400 words]*

*Drawing on available data (e.g., DHCS, Office of Statewide Health Planning and Development, U.S. Census Bureau), summarize the health care needs and disparities that affect the health of your local community.*

Southern Inyo Healthcare District (SIHD) is located in the rural frontier community of Lone Pine in Inyo County. The healthcare needs and community disparities are summarized below.

Access to Care:
Not unlike other rural and isolated communities in California, residents of Inyo County face challenges with securing and establishing continuity care with a primary care physician and lack access to specialty and mental health providers. The entire region has been identified by the Office of State-Wide Health Planning and Development (OSHPD) as a Health Professional Shortage Area (HPSA) and is also classified by Medical Service Survey Area (MSSA) as a Medically Underserved Area (MUA) and Medically Underserved Population (MUP). Inyo County ranks 40 out of 58 Counties in California for health outcomes. Additional social determinants of health places Inyo County ranking 34 of 58 Counties. This factor includes a higher than State average for air pollution, children in single parent households, alcohol related deaths and lack of access to affordable healthy foods which creates a literal food desert for the residents in Inyo County.

Physical Health:
Breast cancer rates in Inyo County are 27.9/100,000 and the State's average is 21.3%. Colorectal cancer is 28.0/100,000 and the California State average is 21.9/100,000. Inyo County ranks 47 out of 58 Counties for Coronary Artery Disease and 34 out of 58 for Stroke.

Behavioral Health: Due to the County being so sparsely populated, there is little to no reliable data on mental health statistics.

Health Disparities: Social determinants of a healthy community looks at six leading factors that can ultimately determine the health status of a particular community and can

assist in creating policies that support population health. These areas are mortality, morbidity, health care access and quality, health behaviors, social factors and physical environment. Adult obesity is 36.2% in Inyo County and the U.S. median is 30.4%. Coronary Artery Disease is 141.9% and HP2020 goals are 103%.
The health disparities described are addressed through the NCQA Patient Centered Medical Home model. The roadmap to PCMH recognition requires specific efforts for addressing chronic disease in the patient population for whom you provide primary care. This would be addressing coronary artery disease, inclusive of hypertension and Diabetes. Additionally, Cancer screening and follow up are integral to PCMH and addresses colorectal and breast cancer rates that are higher than the state average.

### 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.*

As reported by the U.S Census Bureau in 2014, the total population of Inyo County is 18,410. 74.1% have reported to be Caucasian, 19.4% Hispanic or Latino, 3.5% Native American and 3% other. 14.2% report speaking another language other than English in the home. The community of Lone Pine reports 1,890 for its resident population. 26.6% of the population is 18 years of age or younger, 53% are between the ages of 18 and 64 and 26.6% are 65 and older. 78% have completed high school which is lower than the State average of 83%. The major industries in the community that employ residents is construction, transportation, recreation, public administration, education/health, cattle ranching and tourism. The unemployment figures are below the State average at 8.1%. The annual median household income is $45,625. It is important to note that the aforementioned demographics speak to resident populations; however, Inyo County experiences 1.5 million visitors annually who come to the area to visit Death Valley National Monument or Mt. Whitney in the Sierra Nevada mountains. Lone Pine is nestled on a major thoroughfare to Mammoth Mountain Recreation Area, a very popular skiing and hiking destination. The reported injury deaths are almost twice the State average at 86 annually which could be attributed to the transient population which is not accounted for in the Census.

### 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.*

SIHD includes Southern Inyo Hospital and Rural Health Clinic. The Facility is licensed under the California State Department of Public Health to operate a 4 acute care bed

hospital which includes an Emergency Department, and 33-bed skilled nursing facility. Patient care is available at the hospital 24 hours a day, seven days a week. The rural health clinic operates Monday through Friday, 8am-5pm and patients are directed to the Emergency Department for after-hour care. The most recent data available on the payer mix indicates that there was 36% Medicare, 55% Medi-Cal, 4% commercial insurance and 3% uninsured for the rural health clinic. On the hospital side: 61% Medicare, 26% Medi-Cal, 5% commercial and 8% uninsured.

The skilled nursing unit had 39 annual admissions and an average daily census of 29 and the average length of stay was 161.9 days; this includes long- term care range of 14-100 days. The rural health clinic has reported 3,989 unduplicated patient visits for CY 2015.Currently there is no direct delivery of specialty care that is delivered within the Rural Health Clinic. Patients needing higher level of service through subspecialty care are referred to Bishop or Ridgecrest. Future plans do call for implementation of Telemedicine services to reduce unnecessary barriers to care for the patients.

### 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.*

Southern Inyo Healthcare District hospital and clinic are presently using the Healthland HIS for patient accounting. Currently, all patient care is documented in paper charts which is a barrier to efficiently analyzing discrete data, analytics and reporting. Source data for population health analytics come from electronic demographic and claims data alongside manual chart extraction to derive analytic data for reporting on PRIME measures in the present state.

Both acute care and ambulatory operating environments will be implementing advanced electronic clinical documentation technologies. These advanced clinical electronic clinical system technologies integrate clinical charting, CPOE and clinical interoperability for inpatient, outpatient and ancillary departments. This integrated design facilitates a comprehensive care team workflow reducing the potential for medication errors, increases patient engagement with a patient portal offering patients secure communication with their physician and direct access to their individual care records and test results.

The future state of population health analytics and reporting will be derived from patient demographics, claims and clinical electronic health record data. To round out the future

state of Population Health reporting objectives and derive PRIME reporting requirements, the district will be using a third party application from i2i. i2i has an embedded platform specific to NCQA PCMH which supports the PRIME 1.2 Ambulatory re-design project. Furthermore, i2i analytics reporting identifies health disparities in patient electronic records. The strong analytics platform within i2iTracks will allow for reporting through dashboards for use on either a population based report or specific to a provider that can be used in morning huddles. The importance of this cannot be overemphasized as this tool will be at the center of improvement work as the needle is moved towards specific benchmarks within the categories of PRIME SIHD has selected.

As described in the Appendix Infrastructure Building Process Measures, i2i has been chosen as the vendor for reporting out population health measurements. The current challenge is the SIHD has not implemented electronic health records and evaluation for that component is occurring now. SIHD staff and Administration have previewed a demonstration of Open Vista and a site visit is planned within the next 4 weeks.

## 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.*

SIHD's overall goal is to provide an integrated health system which leverages technology, evidence-based protocols and provides a seamless continuum of care. SIHD intends to achieve this by providing the patients and residents of this sparse geographical area that encompasses the District a patient-centric approach to wellness, utilizing the latest technology, ease of access to care, and establishing a foundational relationship which encourages healthy habits and behaviors.

It is the intention of SIHD to implement a coordinated approach using NCQA PCMH standards as a compass to create healthier populations, reduce health disparities and address social determinants of health which has an impact on the quality of life for the resident and patient population in this expansive, sparse area. PRIME will assist in transforming care delivery systems and ultimately meeting the Triple Aim.

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.*

The two overarching aims for SIHD PRIME projects are to increase cancer screening rates at recommended intervals as defined by USPSTF and to provide the residents and patients a patient centered medical home that focuses on whole person care.

For cancer screening, our specific aim is to reorganize the process for identifying patients who are in need of screening, assure care coordination with referral entities and lastly to ensure results are properly documented and follow-up care is coordinated if necessary.

The Patient-Centered Medical Home initiative aims to provide continuity of care with a familiar and trusted care team. Taking into consideration health disparities exist among the population, care will be provided in a manner consistent with the patient's linguistic preference and sensitive to cultural needs. Understanding that social determinants of health have an impact on physical and mental health, SIHD will work with local stakeholders to address identified issues.

SIHD Leadership strongly supports a wellness approach and intends to work diligently to include patient engagement and self-management whenever and wherever possible.

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;*

SIHD selected Ambulatory Care Redesign (Project 1.2) and Cancer Screening and Follow up (Project 1.6). These two initiatives are directly aligned with one another as well as with the mission of SIHD and support the project aim of creating an integrated health system that identifies wellness as a priority for healthy populations and communities.

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*

By engaging in these two projects simultaneously, it will enable SIHD to move more efficiently and effectively to achieve NCQA PCMH recognition. The PRIME projects increase opportunities to address care coordination, novel approaches to delivery of care, identify and address barriers to receiving services in the most appropriate setting and ultimately reduce avoidable Emergency Department visits and hospitalizations

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.*

By the end of the PRIME Project, SIHD will have met the NCQA recommended benchmarks for colorectal, breast and cervical cancer screenings. Through this initiative SIHD will have assisted in lowering the incidence of mortality because of early screening and detection. SIHD will be a leader in Inyo County for patient-centric care that is accessible, sensitive to cultural and linguistic needs, encourages self-management and provides excellent care coordination. Data driven decision making will be hardwired and technology will assist in managing patient populations. SIHD by the end of five years will have a proven track record of reducing avoidable ED visits and hospitalizations and will have a well-developed care system that supports the Triple Aim.

### 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.*

SIHD has selected (2) PRIME Projects: 1.2 Ambulatory Care Redesign and 1.6, Cancer Screening and follow up. As described in section 2.1, there is an increased opportunity to screen, refer, measure and monitor for cancer conditions that are above the State average. This implementation of PCMH to address Ambulatory Care Redesign will lead to the development and implementation of standardized processes, care coordination and panel managers to assist in facilitating referrals. The follow-up for patients will be well coordinated and ensure timely care with the most appropriate provider or setting. This endeavor will assist in reducing the mortality of residents diagnosed with breast, prostate or cervical cancer.

Screening for cancer is a core preventative component for PCMH. The integration of both projects will allow the Organization to simultaneously implement resulting in an efficient service delivery to the patient and achieve one of the objectives of the Triple Aim in lowering the cost for care. The focus of population health and health disparities are woven throughout PCMH from patient education materials translated into a patient's primary language to cultural sensitivity in delivering medical care. Processes will be developed to ensure the community and patients have input when addressing the social determinants of health that are directly affecting the community's health and well-being.

### 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).*

SIHD is managed by Healthcare Conglomerates Associates (HCCA) as a private/public partnership with the SIHD Board. The goals of HCCA and the Directors of SIHD are aligned and both entities agree with the fundamental commitment to a healthy community. This is exemplified by both the Board and HCCA to strive to be the best integrated health system focused on wellness. The mission and vision are parallel with the PRIME objectives of ultimately providing whole person care with the emphasis on prevention and wellness. HCCA has a team in place with vast experience with the previous 1115 Waiver, Delivery System Reform Incentive Pool, or DSRIP, from a public hospital perspective. The team is bringing best practices for process improvement, implementation, novel approaches for barriers to care, lessons learned and an insight on data requirements that are needed for a successful PRIME implementation for SIHD. Both HCCA and the Board of SIHD are committed to PRIME projects that will great improve the health of the community of Lone Pine as well as the surrounding underserved areas of Inyo County.

The HCCA Team provides management oversight to SIHD as a component of the Private Public Partnership. HCCA provides Management level staff including Chief Financial Officer, Interim COO, Vice President of Ambulatory Services, Director of Strategic Planning and Business Development and Human Resources Manager. This Executive level Team works hand in hand with Leadership at SIHD which includes the CNO, Clinic Manager, and other supervisorial staff. In anticipation of the PRIME Initiative, significant work in restructuring the ambulatory care services has been one to lay the platform for data driven decision making. This includes looking at patient level data, compliance with preventative screening recommendations and implementing outreach efforts to patients who fall out of compliance. Reports are then run again, to determine efficacy of these efforts.

The Director of Strategic Planning has weekly calls with the Clinic Manager and staff at SIHD. These calls look specifically at performance improvement work and goals are set for the next week. Goals will continue to be monitored weekly. Additionally, Staff will begin having specific in-service related to PRIME Objectives and their roles as a care team to ensure goals and outcomes are as outlined in the plan. This is also the opportunity for feedback if the plan is not successful to reorganized efforts to produce results that are expected.

### 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.*

SIHD will engage community stakeholders and referral resources in the implementation of PRIME objectives. This will be accomplished by holding meetings with entities that can assist and provide seamless transitions of care. In addition, it is a core objective to work directly with Inyo County Public Health to address specific areas of social determinants and health disparities among the residents of the County that have a direct correlation to the health outcome of the community.

It is the intent to strengthen existing relationships with referral agencies for laboratory and radiology services which have an impact on the success of the cancer screening project. SIHD will look to take a more proactive role in community capacity building to ensure that all facets of PCMH are addressed from a community perspective, not just within the four walls of the medical office.

Stakeholder engagement is difficult at the patient level due to the rural nature of the community. It is difficult for patients to get to the clinic for services and an additional trip is not thought of as a priority. Therefore the plan is to engage referral entities, The District Board which represents the residents and when patients come to clinic appointments to solicit immediate feedback on services and care and offer opportunities for improvement.

### 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.*

SIHD recognizes that cultural competency is much more than just linguistic and cultural norms, but is encompassing of the diverse of populations which we serve. This includes gender, age and LGBTQ peoples.

SIHD leadership will provide all staff yearly training which addresses specific needs of patients from diverse backgrounds, native languages, dialects and norms. In addition, Leadership will engage staff in identifying barriers and will encourage staff to collaboratively seek and implement innovative solutions using PDSA processes. SIHD employs staff that is bilingual in Spanish, the predominant second language of the patients we serve. Given that 1.5 million visitors pass through the Lone Pine community annually, many are foreigners and are in need of medical care. If their primary language is not spoken by staff, the Language Line is used to facilitate patient care and comprehension of care plans. Most patient education materials are available in Spanish, however once SIHD is on the electronic advanced clinical system platform, patient education materials are available in 53 different languages and dialects.

### 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.*

SIHD as described is located in a sparsely populated area and the focus in the past has been meeting the immediate needs of the patients served in the rural health clinic. PRIME affords the opportunity to strategically focus on population health and the growing needs into the future. This will be accomplished through data driven decision making which the new electronic advanced clinical system and i2iTracks platforms will provide. Staff have had little exposure to concepts of health care reform such as the Triple Aim, Population Health or Patient Centered Medical Home. PRIME will take SIHD into the future and beyond by engaging staff in learning collaboratives and trainings which will ensure staff have a strong knowledge base and that these concepts are implemented with Leadership support.

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

### ☒ 1.2 Ambulatory Care Redesign: Primary Care (required for DPHs)

One of the primary goals that SIHD will accomplish through the implementation of the PCMH care model is building the trust and ultimately the relationship between our target population, all patients 18 years of age and older receiving primary care services in the SIHD Ambulatory Clinic.

There are three main focus areas to achieve these goals:

Enhanced Access and Continuity of care- SIHD will build the necessary infrastructure to ensure access to care for both continuity and same day needs. SIHD will evaluate the need for extended hours beyond the traditional and current 8am-5pm access. Identifying alternative care delivery methods, SIHD will increase efforts in the use of Telemedicine and non-face to face encounters.

Population Health Management- SIHD will implement an Advanced Clinical Healthcare Information Technology (HCIT) platform for an electronic health record, as currently the rural health clinic still uses paper charts. To support data extraction and reporting

capabilities, SIHD will install i2iTracks as the population health management tool. Based on clinical data, health assessments and evidence-based guidelines care teams will proactively identify specific care needs including preventative screenings, immunizations and recommended follow-up for patients with chronic disease.

Coordination of Care, tracking and monitoring- With the anticipated implementation of a HCIT and i2iTracks, SIHD will be in an excellent position to track and monitor the health needs of the patients. The robust systems will allow specific reports to be run for morning huddles which in turn will maximize the patient appointment, automatic flagging of abnormal lab or imaging results and triggers to alert care teams when patients are due for annual preventative maintenance such as immunizations and cancer screenings.

SIHD will improve the care for residents of Lone Pine and the vast surrounding communities by addressing both chronic conditions and preventative care needs in a patient-focused manner that requires a team based approach where skill sets and talents of every member of the team are maximized. This organized approach will benefit patients and improve outcomes, because vulnerable populations will be prompted by care teams to receive care when they need it. This patient-centered environment will reduce unnecessary utilization of the Emergency Departments. Having simultaneous focus on both prevention and evidence- based disease management will positively impact health outcomes for the residents of Lone Pine and surrounding communities in the large geographical area of the district.

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

| Check, if applicable | Description of Core Components |
|---|---|
| **Applicable** | **1.2.1** Conduct a gap analysis of practice sites within the DPH/DMPH system. |
| **Applicable** | **1.2.2** Primary care practices will demonstrate advancement of their PCMH transformation through the use of a nationally-recognized PCMH methodology. |
| **Applicable** | **1.2.3** Hiring and training of frontline workforce (e.g., medical assistants, community health workers, promotoras, health navigators or other non-licensed members of the care team) to be responsible for coordination of non-clinical services and elements of the care plan. |
| **Applicable** | **1.2.4** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population/panel management activities, care coordination, patient engagement, and operational and strategic decisions including a system for continual performance |

| Check, if applicable | Description of Core Components |
|---|---|
| | feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.<br>• Implementation of EHR technology that meets meaningful use (MU) standards. |
| Applicable | **1.2.5** Ongoing identification of all patients for population management (including assigned managed care lives):<br>• Manage panel size, assignments, and continuity to internal targets.<br>• Develop interventions for targeted patients by condition, risk, and self-management status.<br>• Perform preventive care services including mental health and substance misuse screenings and brief interventions (e.g., PHQ-9, SBIRT). |
| Not Applicable | **1.2.6** Enable prompt access to care by:<br>• Implementing open or advanced access scheduling.<br>• Creating alternatives to face-to-face provider/patient visits.<br>Assigning frontline workers to assist with care navigation and non-clinical elements of the care plan. |
| Applicable | **1.2.7** Coordinate care across settings:<br>• Identification of care coordinators at each primary care site who are responsible for coordinating care within the PCMH as well as with other facilities (e.g., other care coordinators or PCMH/DPH/DMPH high risk care managers):<br>o Establish onsite care/case managers to work with high risk patients and their care teams, or develop processes for local care coordinators to work with a central complex care management program for these patients<br>Implement processes for timely bi-directional communication and referral to specialty care (including mental health and substance use disorder services), acute care, social services and community-based services. |
| Applicable | **1.2.8** Demonstrate evidence-based preventive and chronic disease management. |
| Applicable | **1.2.9** Improve staff engagement by:<br>• Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. |

| Check, if applicable | Description of Core Components |
|---|---|
| | • Providing ongoing staff training on the team-based care model to ensure effective and efficient provision of services (e.g., group visits, medication reconciliation, motivational interviewing, cognitive behavioral therapy and Medication-Assistance Treatment (MAT)). |
| **Not Applicable** | **1.2.10** Engage patients using care plans, and self-management education, and through involvement in the design and implementation of this project. |
| **Not Applicable** | **1.2.11** Improve the accuracy and completeness of race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI) data, and use that data to identify and reduce disparities in one or more Primary Care Redesign project metrics by:<br>• Adding granular REAL and SO/GI data to demographic data collection processes and training front-line/registration staff to gather complete and accurate REAL/SO/GI data.<br>• Developing capacity to track and report REAL/SO/GI data, and data field completeness.<br>• Implementing and/or refining processes for ongoing validation of REAL/SO/GI data.<br>• Developing capacity to stratify performance metrics by REAL/SO/GI data and use stratified performance data to identify disparities for targeted interventions.<br>• Developing capacity to plan and implement disparity reduction interventions with input from patients and community stakeholders.<br>• Developing dashboards to share stratified performance measures with front-line staff, providers, and senior leadership. |
| **Applicable** | **1.2.12** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. |

## ☒ 1.6 – Cancer Screening and Follow-up

This project was selected by SIHD because the percentages of cervical, breast and colon cancer as described in Section 2.1 is above the State average. In addition, this project aligns itself with 1.2, Ambulatory Care Redesign. SIHD is under the belief that screenings for cancer has either been delayed beyond the USPSTF recommended intervals, has not been offered or patients have not been made aware of the importance of early detection. Therefore, following USPSTF recommended time frames and NCQA PCMH Section 6, Factor 2, SIHD will use the outline of aims below to identify, outreach, inform, provide care or refer as appropriate, all adult patients within the PCMH. This will improve disparate health conditions that prevent SIHD from being the best in class for cancer screening. This project was selected by SIHD because we believe that preventive care is essential to maintain good health and in most instances prevent progression of disease. SIHD recognizes the importance of effectively treating chronic illness, its vision and commitment to patient care is focused on shifting the attention of health care delivery systems from sickness and disease to healthy living, prevention and wellness.

Providers and staff will receive the necessary training to effectively utilize clinical decision support systems made available through the Electronic Health Record. Such CDSS include patient specific alerts and reminders. These will allow the care team to make person specific decisions as to the next level of care needed depending on the information that that's available in the EHR and the results obtained through patient assessment to include POC testing. The CDSS will walk the care team through a clinical workflow that will prompt the necessary follow up and testing to ensure the best patient outcome.

Identifying needs: An initial gap analysis will be completed in DY 11. This will be done through chart review and will continue to be monitored monthly in DY 12 and thereafter through reporting capabilities in i2iTracks.

Referral Process: Referrals for screening colonoscopy and mammography may be initiated by the medical assistant or provider during a patient visit. Additionally, a panel manager will provide inreach to patients that have been identified on reports from i2iTracks as being due for preventative maintenance in these areas. The panel manager and patient navigator will then outreach these patients via phone, text or mail to encourage patient engagement. Standing orders will be developed to assure that barriers to preventative screenings are reduced. This will occur in DY12 and will be continuously monitored to assure patient compliance and support data integrity as reported through i2iTracks.

Outreach: SIHD will use the patient navigator and panel manager to perform inreach to established patients. SIHD will engage in October Breast Cancer Awareness month activities and will promote those activities throughout the community.

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

| Check, if applicable | Description of Core Components |
|---|---|
| Applicable | **1.6.1** Develop a multi-disciplinary cross-participating PRIME entity task force to identify principle-based expected practices for screening and follow-up for the targeted services including, but not limited to:<br>• Standard approach to screening and follow-up within each DPH/DMPH.<br>• Screening:<br>  ○ Enterprise-wide standard approach to screening (e.g., ages, frequency, diagnostic tool).<br>• Follow-up for abnormal screening exams:<br>  ○ Clinical risk-stratified screening process (e.g., family history, red flags).<br>Timeliness (specific time benchmark for time from abnormal screening exam to diagnostic exam). |
| Not Applicable | **1.6.2** Demonstrate patient engagement in the design and implementation of programs. |
| Applicable | **1.6.3** Collect or use preexisting baseline data on receipt and use of targeted preventive services, including any associated disparities related to race, ethnicity or language need. |
| Applicable | **1.6.4** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to USPSTF A and B Recommendations. |
| Applicable | **1.6.5** Improve access to quality care and decrease disparities in the delivery of preventive services. |
| Not Applicable | **1.6.6** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health. |
| Applicable | **1.6.7** Adopt and use certified electronic health record systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population management approaches (e.g., in-reach, outreach) to reduce gaps in receipt of care. |

| Check, if applicable | Description of Core Components |
|---|---|
| Applicable | **1.6.8** Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate. |
| Applicable | **1.6.9** Implement a system for continual performance management and rapid cycle improvement that includes feedback from patients, community partners, front line staff, and senior leadership. |

***Please complete the summary chart:***

| | For DPHs | For DMPHs |
|---|---|---|
| Domain 1 Subtotal # of DPH-Required Projects: | **3** | **0** |
| Domain 1 Subtotal # of Optional Projects (Select At Least 1): | | **2** |
| Domain 1 Total # of Projects: | | **2** |

## Section 5: Project Metrics and Reporting Requirements

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

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

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

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

## Section 6: Data Integrity

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

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

## Section 7: Learning Collaborative Participation

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

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

## Section 8: Program Incentive Payment Amount

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

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

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

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

## Section 9: Health Plan Contract (DPHs Only)

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

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

## Section 10: Certification

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

## Appendix- Infrastructure Building Process Measures

| | Proposed Process Measures | Proposed Milestones | Applicable Project Numbers | Process Measure Start Date – End Date |
|---|---|---|---|---|
| **1.** | Purchase Advanced Clinical Healthcare Information Technology (HCIT) | - Conduct HCIT selection process<br>- Contract for selected HCIT<br>- Implement project plan<br>- Conduct integrated testing<br>- Develop training plan for staff<br>- Conduct system testing<br>- Transition to Productive state (go-live) | 1.2, 1.6 | July 2016 – June 2017 |
| **2.** | Purchase i2iTracks for Population Health Reporting | -Work with vendor on installation post HCIT go-live<br>-Develop training plan for staff<br>-Integrated testing | 1.2, 1.6 | July 2016– June 2017 |
| **3.** | Develop training plan for staff on NCQA PCMH | -Develop curricula<br>-Schedule and conduct all staff training<br>-Assess effectiveness of training | 1.2, 1.6 | July 2016 – March 2017 |
| **4.** | Conduct gap analysis for cancer screening | Identify patient populations<br>Chart extraction on specific screenings<br>Create a baseline for future reporting | 1.2, 1.6 | July 2016 - June 2017 |
| **5.** | Conduct community awareness and outreach to referral sources | Develop training material<br>-reach out to referral sources<br>-presentation to Board of Directors | 1.2, 1.6 | July 2016 – Sept 2017 |

Work Cited

"California Department of Public Health (CDPH) California Cancer Registry." Available at: http://www.cdph.ca.gov/Pages/DEFAULT.aspx

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"Center for Disease Control, Improving Community Health, 2014." Available at: http://www.cdc.gov/

"Inyo County Health and Human Services First Five Commission, Family Prevention 2013." Available at: http://www.inyocounty.us/publichealth/

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