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**

El Camino Hospital

2500 Grant Road

Mountain View, CA 94040

Table of Contents

General Instructions

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

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

Scoring

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

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

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

Section 1: PRIME Participating Entity Information

Health Care System/ Hospital Name El Camino Hospital

Health Care System Designation (DPH or DMPH) DMPH

Section 2: Organizational and Community Landscape

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

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

El Camino Hospital District is located in Santa Clara County (SCC), California, south of San Francisco Bay. With a population estimated at 1.8 million, it is one of the most populated counties in California.[1] It is also one of the most affluent in the United States, due in large part to the settling of a multitude of technology (high tech) giants in the region.

Coverage: Despite the high percentage of the population with health insurance (87%)[2], many residents report an inability to receive healthcare, as follows: uninsured (36%), lower income groups (29%), unemployed residents (16%) and foreign-born residents (15%), indicating disparities in access to health care. 13% of residents are uninsured. Of the 87% with insurance, 17% are on Medi-Cal.[3]

Behavioral Health: Twenty percent of students in grades K-12 are suffering from a mental health issue on any given day.[4] Improved mental health is the 4th health need priority in Santa Clara County. Four in 10 adults reported "poor mental health" at least one day out of the past 30 (increased from 1 in 4 in 2013), with ethnic breakdown as follows: African-American (47%), Hispanic (41%), White **(**33%), and Asian/Pacific

Islander (25%). The 7th health need priority is substance use disorder and binge drinking.[5] One in 7 adults and 1 in 9 adolescents in SCC reported binge drinking in the past month. Tobacco use is noted in 1 of 10 adults and 1 of 12 adolescents.[6]

Physical Health: Chronic Disease: Fifty percent of SCC adults and 33% of adolescents are overweight or obese, contributing to the significant burden of heart disease and diabetes. 8% of the County's residents have diabetes and 22% of deaths are due to heart disease.[7]

Perinatal Health: Infant birth outcomes are noted as the 11th health needs priority for Santa Clara County, [8] as marked by the percentage of low birth weight babies in Santa Clara County, despite the high level of income and insurance coverage. In 2012, low birth weight babies make up 6.8 percent of all births. African American babies are the highest risk group for low birth weight with 6.9/1,000 births compared to 2.9/1,000 for other ethnicities. This health need is impacted by social determinants of health and the percentage of women receiving prenatal care. Barriers include the cost of care, poor access to primary care providers and specialists due to lack of insurance, lack of knowledge and language and cultural issues.[9]

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.

Income: Juxtaposed to its considerable affluence, Santa Clara County data indicates a high level of homelessness, poverty and other social indicators of poor health. The median income was $91,425 in 2010, with Asian/Whites earning $100,000 annually and Hispanics earning significantly less at $55,000 per year.[11] Eleven percent of adults and 13% of children are living below the federal poverty level .[10]

Race/Ethnicity: Whites and Asians each accounted for approximately one-third of the county population (34% and 33%); more than a quarter of the population is Latino/Hispanic (27%), and only 3% African American.[10] Thirty-seven percent of county residents are foreign-born, with origins in Mexico (21%), Vietnam (15%), India (13%), Philippines (9%), and China, excluding Hong Kong and Taiwan (8%).[12]

Language: While English is the predominant language in Santa Clara County, more than 50% of residents speak another language at home. These are noted as follows: Spanish (37%), Mandarin (15%), and Vietnamese (13%).[13]

Age: The median age of Santa Clara County residents is young, at 37 years: age 0-17 (24%), age 18-64 (65%), age 65 or older (12%).[13]

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.

El Camino Hospital (ECH) is a general acute care hospital with 300 beds, 25 of which are licensed as acute psychiatric beds. ECH provides the full range of acute tertiary services including: cancer, neurology, orthopedics, and behavioral health, basic emergency and surgical/interventional procedures. It has a busy surgical service with over 7200 cases annually, averaging 139 per week.

ECH provides the full continuum of inpatient/outpatient services for Mother/Baby care, including labor and delivery, newborn nursery, lactation classes, birthing classes and newborn care in the state-of the-art Women's Hospital.

ECH also owns and operates two primary care clinics: Silicon Valley Primary Care and the Senior Health Center dedicated to geriatric care. A psychiatrist was recently added to this team to develop increased screening for behavioral health issues in seniors.

The behavioral health program was established in 1961. The 25-bed psychiatric unit provides acute psychiatric care to adults with an average length of stay of 5 days. The majority of behavioral health admissions come through the ECH emergency department on a 5150 involuntary hold.

ECH provides the behavioral health continuum of care through its outpatient partial hospitalization program and intensive outpatient services such as the adolescent intensive outpatient program "ASPIRE". This best practice program has been a great example of community partnering to address an identified health need-- the crisis of adolescent suicide in Santa Clara County.

The ECH inpatient payer mix for FY 2015 is 54% commercial, 30% Medicare, 6% Medi-Cal, and 5% self-pay. Outpatient Medi-Cal is 11%

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.

ECH utilizes the EPIC Electronic Health Record system throughout the organization. EPIC is advantageous as an EHR due to its high penetration in many hospital and county systems, enabling data bridges between organizations. EPIC continues to optimize the platform at ECH and continues to improve system design in specialty areas such as behavioral health.

ECH has an established Quality Committee of the Board of Directors that oversees quality and performance improvement in the entire organization. The Medical Staff Quality Committee reports to the Board of Directors directly on all matters pertaining to quality and patient safety. The committee is charged with monitoring all required data for CMS, the Joint Commission, National Patient Safety Goals, CDPH, and others. The committee ensures that data is collected and monitored under the Plan-Do-Check-Act quality improvement model. An incident monitoring system is in place and electronic data reporting is available through the EHR. This system has the capacity to collect data and develop specialized reports through EPIC's ongoing Super-Users Input group, making it one of the leading EHR systems available.

The MayView Community Health Center has many years of experience in reporting data due to its FQHC Look-Alike status. ECH will collaborate with MayView on reporting required measures and ensuring that the data is collected to support the quality improvement effort required in implementing the collaborative perinatal program.

One barrier to the PRIME project data reporting is that resources for new FTEs are limited. The infrastructure-building process will identify needed resources for PRIME program monitoring and reporting. The required Perinatal Care measures are currently being monitored, as are the Blood Management indicators. This historical data will be used to establish quality improvement goals. Behavioral health quality indicators are less proscriptive. ECH has evaluated a number of voluntary measures for Behavioral Health quality measurement.

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.*

ECH's overall goal is to be "a locally controlled leader in optimizing the health and wellness of our communities in Silicon Valley, differentiating by innovative continuum of care development in partnership with physicians, businesses and payers."

Through implementation of the PRIME 5 year plan ECH achievements will include: top decile performance on CMS value purchasing metrics and service levels, extending clinical services for chronic conditions into the community, advancing physician collaboration through aligned incentives, and patient-centered care delivery throughout Silicon Valley as well as Continuum of Care development for Behavioral Health.[13]

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.*

A. Expand the current continuum of care for behavioral health by integration of behavioral health into primary care and the emergency department. This expands screening of undetected mental health and substance use disorders in a familiar setting and provides early intervention/prevention assistance. It also allocates pre and post emergency care services.

B. Improve and expand perinatal care for underserved women; particularly Medi-Cal mothers who deliver at ECH without prenatal care. Reduce high-risk emergent deliveries at ECH.

C. Increase stewardship of blood utilization by implementation of a nationally recognized Patient Blood Management program.

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;*

The integration of physical and behavioral health care is the best approach to the aims and goals of ECH. The hospital has already adopted the values and philosophy of population health management and every project supports this organizational goal. ECH has embraced the whole person care philosophy consistent with the Affordable Care Act and will continue to carry out its mission through the PRIME projects and others. The PRIME goals are consistent with the ECH philosophy creating a natural blend of strategy and mission for this safety net hospital.

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*

The integration of primary care and behavioral health through MayView CHC will address perinatal health for Medi-Cal moms as well as behavioral health needs. The ECH behavioral health program provides postpartum depression services, which will be available for Medi-Cal moms. As moms are referred to MayView for perinatal care, they will have access to BH resources including screening for depression and substance use disorder. During the 5-year PRIME project plan, services to the primary care patients at ECH outpatient clinics will expand. As co-located BH providers are available in the primary care clinics, the care of co-morbid chronic conditions will improve. Access to behavioral health care will improve physical and mental health for these patients, and extend life expectancy for many.

In addition, the Blood Management program intersects with the Perinatal Services Program by monitoring blood utilization and developing standards of care for hemorrhage situations that minimize transfusion and the attendant risks.

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.*

ECH will achieve an integrated, coordinated system of BH care with its community partners. The placement of BH providers in the clinics will improve care of behavioral health patients in that they receive care for their co-morbid physical health conditions in a familiar clinic environment. The use of screening tools, such as the PQH9 and SBIRT, in the outpatient environment will identify unmet behavioral health needs in the primary care population and allow for early intervention. Through the expansion of the BH Continuum of Care patients will get to the right place, at the right time for appropriate care. ED boarding times will be reduced and patient satisfaction in the ED will be improved. Through collaboration with MayView CHC, Medi-Cal and uninsured

moms will have access to ECH services. A Patient Blood Management Program will be developed, through which providers will receive ongoing training on best practices in transfusion medicine and appropriate utilization of blood products. Evidence-based guidelines will be adopted and protocols established improving care and safety for all patients receiving blood/blood products.

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.

Developing the full Continuum of Care through a collaboration/integration model will address the disparities in physical and behavioral health care for Medi-Cal beneficiaries in Santa Clara County. The plan for behavioral health and primary care integration will improve access to a behavioral healthcare continuum and will link beneficiaries to services in the community. This will address boarding times in the ED and improve care for BH as well as other ED patients. New resources will be developed and identified to address the outpatient care needs of BH patients.

Expansion of inpatient beds will increase capacity for Santa Clara County psychiatric patients needing inpatient care, including Medi-Cal and the uninsured. This is critical due to the significant shortage of inpatient psychiatric beds in Santa Clara County and Northern California in general.[16]

Expanding the adolescent continuum of outpatient mental health care to middle school students and young adults increases access to services for suicide prevention and other mental health disorders requiring early detection and prevention.

Implementing the PRIME perinatal program will address the needs of Medi-Cal moms delivering without perinatal care, improving health outcomes for those mothers and babies.

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).

The ECH PRIME Steering Committee is a multi-disciplinary committee charged with guiding the development and implementation of the PRIME projects, as well as monitoring of required PRIME project measures. The PRIME Project Director oversees the implementation of the 5-year plan and reports to the Quality Committee at ECH; as well as directly to the CMO, CFO, COO and/or Chief Strategy Officer. This reporting structure will be finalized during the 3 month infrastructure building period. Each PRIME project has a Project Director who works with a project team to develop and implement the operational changes necessary to successfully meet the milestones and demonstrate improvement on the metrics. The PRIME Project Director ensures that the three project managers have the support and coordination with senior leadership to ensure successful accountability for the projects. The PRIME Steering Committee ensures that the Project Managers have the time, staff and technological resources needed to successfully complete the work.

As PRIME projects are developed, the Quality Committee will ensure that required metrics are collected and reported. They will also ensure that the process measures are achieved through coordination with the PRIME Steering Committee.

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.

ECH has an award-winning relationship with the National Alliance for Mentally Ill (NAMI) and was awarded California Provider of the Year in 2015. ECH will collaborate in this professional relationship to further plan and develop the Continuum of Behavioral Health Care. As services are planned and introduced,

focus groups and surveys regarding achievement of PRIME goals will be conducted.

Stakeholders include the uninsured and Medi-Cal patients accessing services at ECH. Through partnership with MayView CHC, a Patient Advisory Council will be created to provide input in the design and implementation of the behavioral health continuum and the enhanced perinatal care services. .The Council will meet quarterly and will review work plans, goals, barriers and progress on the PRIME initiatives. Their comments will be important in issues-resolution and ensuring that all patients have access to quality services through both MayView CHC and ECH.

Quarterly random surveys will be offered to patients in the ECH ED. All Medi-Cal mothers delivering at ECH will be surveyed for prenatal care access and where they received those services. Data will be shared across the continuum of services.

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.

Ethnic diversity is noted throughout the ECH organization, reflective of the community we serve. All staff, including caregivers, receives cultural competency training upon hire, with an emphasis on the cultural mix in the community.

ECH is sensitive to the needs of mental health and substance use disorder patients, and staff is committed to reducing stigma across all services. The ED plan calls for training in behavioral health interventions and role-modeling positive interventions for behavioral health patients.

The Patient Navigator in the ED will be a lay person from the community, reflecting one of the dominant cultures. This individual will provide culturally competent communication with patients, ensuring that patients can get the care they need.

The need for behavioral health services creates shame and stigma in many cultures. It is important to understand each culture's likelihood of suicide, willingness to seek care, substance use issues and others as we build programs that work with the patient's culture, not against it.

Similarly, the cultural issues related to perinatal care, childbirth and blood transfusions are very specific to ethnicity. It is essential for clinical staff to understand cultural norms of their patients and develop their care plan appropriately to ensure the patient's well-being.

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.

ECH has provided care to the community for over 50 years and has a successful infrastructure to manage quality and improve the care of the patients we serve. The PDCA model is firmly established in the continuous quality improvement process and all staff is trained in that philosophy. Many rapid cycle improvement projects have been successful in redesigning workflow. ECH plans service improvements based on data analysis of community needs and develops implementation plans that are effectively implemented on a timely basis.

The hospital implemented a major building program on the Mountain View campus to replace over 300 beds in 2009, demonstrating its long-term commitment to Santa Clara County residents. ECH leadership expects the same rigor of past projects to be applied to the PRIME program, especially since the PRIME proposal is a roadmap and action plan for El Camino Hospital goals.

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 <u>each</u> selected project. Provide narrative responses in the spaces marked "*[Insert response here]*":

1. *Summarize your approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words]*
2. *Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]*
3. ***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

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

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]

Rationale

ECH has been serving behavioral health patients since 1961. The inpatient unit, partial hospitalization program, adult intensive outpatient program and adolescent IOP program provide services to adolescents, adult and seniors. Behavioral health presentations to the Emergency Department have been increasing with more people insured commercially or with Medi-Cal. ECH chose this project to expand the continuum of care for BH patients and to improve outcomes through integration in primary care.

ECH has determined that collaborating with community partners who serve Medi-Cal patients is the best way to expand and integrate BH into primary care. The MayView CHC is geographically close to ECH and is responsible for 5,000 Medi-Cal beneficiaries in Santa Clara County.

Through partnership with MayView Community Health Center, ECH will provide BH resources in the emergency department, referring patients to the ECH BH program as indicated, and also referring patients to MayView Clinic for coordination with primary care providers. Additionally, ECH will provide mental health intervention and navigation services at the MayView Clinic, providing and/or referring patients to mental health services as needed.

Implementation

Using a co-location model, placing a BH provider at MayView, BH screening and intervention using the PHQ-9 depression screening tool will identify untreated BH issues for Medi-Cal patients. In addition to screening and prevention services, ECH will help to

develop post-acute stabilization services at MayView in order to increase resources for BH patients who currently seek care in the ED.

The goal of this collaboration is to improve access to BH services and also improve healthcare outcomes for Medi-Cal recipients through the timely identification and treatment of mental health conditions.

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

Target Population. The target population is Medi-Cal beneficiaries with mental health conditions including depression, bipolar, addiction, perinatal mood disorder, and thought disorder.

Vision for Care Delivery

This project will improve the staff's understanding of behavioral health screening and interventions. Point persons at ECH (Patient Navigator, BH staff) and at MayView (case managers, clinicians) will collaborate to develop workflows for identification of patients at risk and in need of behavioral health support. In addition, cross-referral pathways will be developed and implemented to strengthen the BH continuum of care in the community.

Standardized, nationally endorsed screening tools and protocols will be adopted by the project partners to ensure that all care partners are speaking the same language and interpreting risk scores in the same way. This will ensure that patients receive standard messaging and treatment, and that disparities in care are reduced and/or eliminated.

Skills learned in population health management will allow the clinical teams to apply this approach to other populations in the future, thereby expanding the reach of the quality/ safety improvement focus.

PRIME planning efforts have already yielded a contract with Santa Clara Family Health Plan to deliver babies to Medi-Cal mothers through a referral arrangement. This contract has created a new access point for obstetrical care in the ECH service area.

3. *Infrastructure-building process measures* – Yes. See Appendix 2.

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)
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)
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.
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.

Check, if applicable	Description of Core Components
Applicable	**1.1.6** Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families.
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.
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.
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.
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.
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.

Check, if applicable	Description of Core Components
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.
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.
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.
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:

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

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

☒ 2.1 – Improved Perinatal Care (required for DPHs)

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]

Rationale

In 2015, El Camino Hospital delivered 153 babies to Medi-Cal mothers and 23 to uninsured/indigent patients. These Medi-Cal mothers may not have received prenatal care, due to a lack of knowledge, insurance, access, language barriers, or cultural issues. The deliveries at ECH for this population are frequently not pre-planned, with women coming to the emergency department without previous contact. Women without prenatal care are more likely to have low birth weight children, especially African American mothers at 6.9/1000, as compared to 2.9/1000 in other ethnicities.[18]

Approach

Evaluation of the local demographics and access to services revealed that MayView Community Health Center is assigned 5,000 Medi-Cal members under the Santa Clara Family Health Plan. MayView provides clinical and case management services under the California Comprehensive Perinatal Services Program. The goal is to improve access to perinatal care, improve birth outcomes, and reduce high-risk deliveries. Through collaboration with MayView for perinatal care, Medi-Cal moms will receive referrals at every contact with ECH to seek care at MayView for their own health and that of their newborn. MayView will provide prenatal care, including perinatal case management services, as needed. Newborns will be delivered at ECH under a new contract with Santa Clara County Family Health Plan that is currently under negotiation. Patients will receive their postpartum care at MayView. They will be screened at the MayView Clinic for post-partum depression and have access to a co-located hospital-employed therapist. These mothers will have access to the perinatal mood program at El Camino Hospital, should they require intensive services.

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

Improved perinatal care for our population will enable MediCal moms to receive high quality perinatal services in their community, in our effort to improve patient outcomes. The collaboration and integration with MayView clinic will support improved perinatal care for Medi-Cal moms who are presenting at ECH emergency departments. To accomplish this we plan to:

1) Develop protocol to educate moms about perinatal services at MayView. ECH will develop new workflow to improve identification and access to services through our emergency departments. This will:
   a) Increase utilization of perinatal care by Medi-Cal moms.
   b) Encourage efficient use of healthcare resources in our community.
   c) Create a new access point for obstetrical deliveries for Medi-Cal recipients

2) Identify gaps in the continuum of perinatal services and problem-solve to fill the gaps with local resources. ECH will monitor the impact on the target population through clinical outcomes. This will enable ECH to collaborate with primary care to further optimize perinatal services across the continuum.

3) Allocation of care coordination resources for follow up care. This will include integrated case management services, EHR system changes, and generation of follow-up reports to ensure connection of service. This will enable ECH to:
   a) Connect and follow Medi-Cal moms through the continuum of care.
   b) Encourage and facilitate collaboration among community providers. Closely monitor patient needs and outcomes.
   c) Increase understanding of resources needed to support Medi-Cal moms.

3. *Infrastructure-building Process Measures* – Yes, see Appendix 2.

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

Check, if applicable	Description of Core Components
Applicable	**2.1.1** DPHs/DMPHs engagement in best practice learning collaborative to decrease maternal morbidity and mortality related to obstetrical hemorrhage (CMQCC/PSF/HQI combined effort).
Not Applicable	**2.1.2** Achieve baby-friendly hospital designation through supporting exclusive breastfeeding prenatally, after delivery, and for 6 months after delivery and using lactation consultants after delivery.
Applicable	**2.1.3** Encourage best practice and facilitate provider education to improve cesarean section rates, and decrease inequities among cesarean section rates. Participate, as appropriate, in statewide QI initiatives for first-birth low-risk cesarean births.
Not Applicable	**2.1.4** Coordinate care for women in the post-partum period with co-morbid conditions including diabetes and hypertension.

Please complete the summary table below:

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

Section 4.3 – Domain 3: Resource Utilization Efficiency

☒ 3.4 – Resource Stewardship: Blood Products

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] 263

Rationale

Patient-centered blood management is an evidence-based, multidisciplinary approach designed to improve patient outcomes and the inappropriate use of blood transfusions. Evidence suggests that in a significant number of patients the risk and of a blood transfusion can outweigh the benefits.

Results from the 2011 National Blood Collection and Utilization Survey (NBCUS) note that only 30% of hospitals reported having blood management programs and 15% have adopted some patient blood management (PBM) practices. This has already resulted in an 8.2% reduction in transfusions since 2009, with 1.2 million fewer adverse transfusion-related events. Nationally, the average cost to a hospital for a unit of blood is $225, with the cost of administration this can increase to $1,000 or more. Data from two decades of PBM programs in California hospitals indicates that PBM program can assist hospitals with minimizing expenses. ECH anticipates a potential savings of $500,000 over two years by reducing RBC utilization per evidence-based practice.[20-25]

ECH is implementing a Patient Blood Management Program (PBMP) to support the over 7200 surgical cases performed annually. ECH and its consulting vendor will develop the PBMP through the ECH Transfusion Committee. This committee reports to the hospital's Quality Committee, which will monitor the implementation of the PBMP, the impact on clinical outcomes and resource utilization goals.

The PBMP will incorporate the review and management of all blood products ordered and transfused. There is an increasing awareness of the limited clinical efficacy of blood transfusion, the increasing concerns regarding its safety and the dwindling blood supply. Implementing a Patient Blood Management Program is an evidenced-based approach to these issues.

2. Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]113

The Patient Blood Management Program will benefit all patients at ECH requiring transfusion of blood or blood products. By improving clinician awareness of best practices in blood utilization, fewer units will be transfused, thereby reducing the risk of patient complications related to incompatibility, transmission of infection, etc. Patient safety will be enhanced through new evidence-based protocols requiring justification for each unit of blood ordered. Resources will be contained by judicious ordering of blood and reducing waste, which will also preserve the local and national blood supply.

ECH provides over 7,200 surgeries annually to support its wide range of health care programs. All patients receiving care in these services will benefit from the PBMP.

3. Infrastructure-building Process Measures – Yes, see Appendix 2.

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

Check, if applicable	Description of Core Components
Applicable	**3.4.1** Implement or expand a patient blood products management (PBM) program.
Applicable	**3.4.2** Implement or expand a Transfusion Committee consisting of key stakeholder physicians and medical support services, and hospital administration.
Applicable	**3.4.3** Utilize at least one nationally recognized patient blood management program methodology (e.g., The Joint Commission, AABB).
Applicable	**3.4.4** Develop processes for evaluating impact of blood product use including appropriateness of use, adequacy of documentation, safety implications, cost, and departmental budget impact. Develop a data analytics process to track these and other program metrics.
Applicable	**3.4.5** Establish standards of care regarding use of blood products, including: Use of decision support/CPOE, evidence based guidelines and medical criteria to support and/or establish standards.

Check, if applicable	Description of Core Components
Applicable	**3.4.6** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.
Applicable	**3.4.7** Develop organization-wide dashboards to track provider level blood use patterns. Dashboard to include comparisons to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.
Applicable	**3.4.8** Participate in the testing of novel metrics for PBM programs.

Please complete the summary table below:

Domain 2	For DPHs	For DMPHs
Domain 3 Subtotal # Of Optional Projects (Select At Least 1):		1
Domain 3 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 $ 4,680,000
- DY 12 $ 4,680,000
- DY 13 $ 4,680,000
- DY 14 $ 4,212,000
- DY 15 $ 3,580,200

Total 5-year prime plan incentive amount: $ 21,832,200

Section 9: Health Plan Contract (DPHs Only)

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

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

Section 10: Certification

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

Appendix 1: Citations and References

Citations

1. 2014 Santa Clara County Community Health Assessment
2. Ibid.
3. US Census Bureau, American Community Survey, 2010-2014
4. 2014 Santa Clara County Community Health Assessment
5. El Camino Hospital Community Health Needs Assessment-2014
6. 2014 Santa Clara County Community Health Assessment
7. El Camino Hospital Community Health Needs Assessment 2014
8. Ibid.
9. Santa Clara County Community Health Assessment 2013
10. Maternal, Infant, Child Health Brief Santa Clara County 2014
11. US Census Bureau, American community Survey, 2010-2014
12. 2014 Santa Clara County Community Health Assessment
13. Ibid.
14. US Census Bureau, American community Survey, 2010-2014.
15. El Camino Hospital Strategic Plan -date?
16. 2014 Santa Clara County Community Health Assessment
17. Ibid.
18. California Hospital Association “California Acute Psychiatric Bed Loss” 2013
19. El Camino Hospital “Strategy”, El Camino Hospital Website

References-Patient Blood Management Program

20. Busch, M.P. et al. (2003). Current and emerging infectious risks of blood transfusions. *Journal of the American Medi-Cal Association,* (289) 959-962.

21. Goodman, C. et al. (2003). Ensuring blood safety and availability in the US: Technological advances, costs, and challenges to payment-Final report. *Transfusion* (43) 3S-46S.

22. C Goodnough, L.T. (1999). Transfusion Medicine. Blood Transfusion. *New England Journal of Medicine.* (340), 438-447.

23. D. Hanada, A. et al. (2000). Prevalence of a newly described cricovirus, TTV, I United States donors. *Transfusion* (40), 245-251.

24. E.Redhead, C.S. et al. (2000). *CRS report for Congress-blood and availability: Managing supply to meet a growing demand.* Library of Congress.

25. Sonnenberg, F.A. (1999). The cost-effectiveness of preoperative autologous transfusion revisited: Implications of an increased risk of bacterial infection with allogeneic transfusion. *Transfusion* (39) 808-817.

Appendix 2: Infrastructure-Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
1.	• Baseline data reports available for September 30 2016 report to State	• Configuration of EPIC reports to support PRIME metrics data capture and reporting	1.1 2.1 3.4	Jan 1 2016 to June 30 2016
2.	• Perinatal patients screened positive for depression at clinic assessed and referred for treatment • Patients presenting for delivery with evidence of appropriate prenatal care	• Completed plan for BH services integration with perinatal care at MayView CHC including data collection and measurement for the target population	1.1 2.1	Jan 1 2016 to June 30 2016
3.	• Available BH appointments located at MayView CHC • Patients screened positive for depression at clinic assessed and referred for treatment • Patients screened positive for substance use disorder using SBIRT assessment tool assessed and referred for treatment	• Completed plan for integrated BH screening and intervention for patients at MayView CHC including data collection and measurement for the target population.	1.1	Jan 1 2016 to June 30 2016