
# Public Hospital Redesign and Incentives in Medi-Cal (PRIME) 5-Year PRIME Project Plan

Application due: **by 5:00 p.m. on April 4, 2016**

## Table of Contents

## General Instructions

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

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

### Scoring

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

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

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

## Section 1: PRIME Participating Entity Information

| | |
|---|---|
| **Health Care System/Hospital Name** | El Centro Regional Medical Center |
| **Health Care System Designation (DPH or DMPH)** | DMPH |

## Section 2: Organizational and Community Landscape

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

**2.1 Community Background.** *[No more than 400 words]*
*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 Centro Regional Medical Center (ECRMC) is located in El Centro, California, and stands as the principal city of the County of Imperial. ECRMC patients face many healthcare disparities, including our rural geographic location, an ethnic community makeup, low socioeconomic status and literacy rates, limited access to public transportation and high levels of air pollution.

Access to care has long proven to be a major challenge for our community and its citizens. In 2012-13, there was one primary-care physician for every 4,170 Imperial County residents, compared to one for every 1,341 residents statewide. The Imperial Valley's geographic location and high summer temperatures (120°F) make it difficult to recruit and retain qualified providers for both primary and specialty care.

Ethnically, 82.3% of the community is Hispanic, 32% of whom are foreign born. Latinos are statistically more likely to suffer from serious health conditions including asthma, diabetes, and obesity, all three of which are prevalent in Imperial County.

41% of Imperial Valley residents lack basic literacy skills, including those who could not be tested due to language barriers. 70.6% of residents speak a language other than English in the home. While there is transportation, the public transit system is limited, particularly in the outlying areas.

In 2015, the Imperial County led the state in total number of children treated in the emergency room for asthma related issues. Currently, Medi-Cal and Medicare pay for 63% of our asthma-related emergency department (ED) visits and 67% of the asthma-related hospitalizations for both children and adults. Air quality in the Imperial Valley ranks amongst the worst in the US for 11 of 14 categories in the US Air Pollutant Report.

78% of the adult population in Imperial County are overweight or obese, compared to 60% statewide. For 2-5 year olds, 29.9% were obese, compared to 33.4% statewide. For 5-20 year olds, 41.2% were obese compared to 42% statewide.

An Imperial County study of 118,067 adults found that 12,869, or 11%, had Type 1 or insulin dependent diabetes. Diabetes prevalence along the US/Mexico border region is found to be about twice as high as in California as a whole. In 2012, the diabetes prevalence rate in Imperial County was 11%, the highest of all California counties, compared to a prevalence rate of 8.4% statewide.

### 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.*

ECRMC primarily serves the diverse populations of Imperial County. Imperial County is the 9th largest county in California, covering an area of 4,597 square miles. In 2014, the population was estimated to be 180,672, with more than three-fifths of this population living in its three largest cities: El Centro, Calexico, and Brawley. In addition to these cities, there are several surrounding cities and townships that are served by the hospital and its clinics.

**Income**: The average per capita income in Imperial County is $16,409, and the median family income is $41,772. Imperial County has the second highest percentage of unemployed people of any county in the United State (23.6%), and 20.02% of the population live at or below the poverty level, compared to 12.9% statewide and 11.8% nationally.

**Race, Ethnicity, and Language**: The population of Imperial County breaks down as follows:

- 82.3% Hispanic or Latino
- 12.3% White (non-Hispanic or Latino)
- 3.5% Black or African-American
- 2.6% American Indian and Alaskan Native
- 2.3% Asian
- 1.7% Two or More Races
- 0.2% Native Hawaiian

The primary languages spoken are English and Spanish.

**Age**: The population is younger than the state overall with a median age of 31 years old. The population age breakdown is as follows:

- 31.4% 0-18 years
- 9.9% 18 to 24 years
- 30.4% 25 to 44 years

- 18.2% 45 to 64 years
- 10.1% 65 years or older

**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.*

ECRMC is an acute-care medical facility, serving the health care needs of the Imperial Valley since 1956. What started as a 34-bed licensed hospital has grown to 161 licensed beds in order to address the growing population and demand for services in the region. ECRMC has four outpatient centers which deliver patient-care throughout the Imperial County. Our two primary care outpatient clinics are located in the cities of El Centro and Calexico. ECRMC also has a Wound Healing Center which provides traditional wound care and hyperbaric (HBO) treatment on an outpatient basis and an Oncology and Hematology Center.

Other services provided include:

- Emergency Services (Level II Emergency Department, Level IV Trauma designated)
- Intensive Care Unit (12 beds)
- Laboratory Services
- Medical Imaging
- Maternal Child Services (Pediatrics 12 beds, Labor and deliver and OB/GYN services and well-baby nursery)
- Inpatient and Outpatients Surgical Services
- Medical Surgical Nursing Care Unit (72 acute care beds)
- Nuclear Medicine
- Inpatient Rehabilitation (Physical Therapy)

In 2015 the ECRMC payer mix was:

- Medi-Cal
  - 10.3% Medi-Cal FFS
  - 27.9% Medi-Cal Managed Care
- 40.4% Medicare Traditional
- 2.9% Medicare Managed Care
- 16.0% Commercial
- 2.5% Other Payer

In 2015, there were:

- Inpatient Admissions - 6,016
- Outpatient Visits -140,202, including
  - El Centro Outpatient Clinic Visits - 32,693
  - Calexico Outpatient Clinic Visits - 20,158
- Surgeries - 4,252
- ED Visits - 50,089

**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.*

***Data Collection***: ECRMC currently utilizes multiple electronic medical record (EMR) systems to report and monitor data, which will be leveraged to support PRIME. Our primary EMR systems include: Affinity, eCW, Medhost, Soft, GE – CPN-OB, GE –CPM-CPA- Surgery, Siemen Soarian, Wound Tracker, and Agfa. These disparate systems were designed to operate and function according to ECRMC standards and processes at the time of their deployment, but we recognize the importance of streamlining our systems going forward to support PRIME.

***Reporting****:* Our ability to report data largely hinges upon the connectivity and cross-referencing capabilities of each system. Many current reporting requirements call for timely and labor-intensive cross-correlation of data and systems in order to present all of the required content.

***Monitoring****:* The information provided in our regular reports and dashboards is used to identify areas where rapid cycle improvement projects will be most effective to improve the patient experience, the overall population health and reduce costs. These monitoring processes will be critically important to ensuring that the PRIME projects are effectively making improvements.

***Potential Barriers***: As identified above, the use of multiple EMRs is a barrier that will need to be overcome to implement PRIME reporting. The poor inter-connectivity, lack of individual EMR breadth, and overall infrastructure shortfalls will need to be swiftly addressed in order to achieve maximum success through the PRIME program.

To address these barriers, ECRMC plans to implement the following strategies:

- Implement a dedicated PRIME Task Force for data collection, reporting and performance monitoring to ensure that all PRIME requirements are met
- Enhance EMR applications and inter-connectivity through infrastructure building

- Expand IS personnel in an effort to enhance our data collection, reporting and monitoring capabilities

## 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.*

ECRMC's overarching goal is to improve access to care for our patients by providing culturally competent, evidence-based, person-centered care. We are moving toward a population health management model across the continuum of care.

As part of PRIME, ECRMC intends to deploy effective approaches to guide patients and their families through the full continuum of care, including a focus on improved care management and care transitions to reduce avoidable utilization of acute care services. This will support delivery shift from reactive illness management towards illness prevention and wellness promotion, including addressing clinical and social needs.

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

The PRIME program offers areas of intense focus and scrutiny which we intend to build off of to achieve our broader, long-term organizational goals to transform the delivery of care. We have specific aims built into each of our three selected projects which will

provide improvements in care at both the departmental, and eventually an organizational level.

Overarching aims across our three projects include; 1) Improving patient care and follow-up across our health systems in order to combat the significant illnesses within our region, and 2) Improving data tracking and connectivity through our information systems.

In terms of Ambulatory Care Redesign: Primary Care (Project 1.2) our specific aims include: 1) Becoming a recognized Patient Centered Medical Home facility, 2) Increasing the provision of recommended preventative health services available to patients, 3) Decreasing preventable acute care utilization, and 4) Reducing health disparities for our patients.

In terms of our Obesity Prevention and Healthier Foods Initiative (Project 1.7), our specific aims include: 1) Assuring all patients within our clinic settings receive appropriate BMI assessments and screenings, and 2) Assuring that our hospital offers a nutrition and wellness program that focuses on wholesome, fresh nutritious foods that are readily accessible.

In terms of our Resource Stewardship High-Cost Imaging Project (3.2), our specific aims include: 1) Reducing the number of unnecessary and inappropriate studies, and 2) Improving the use of evidence-based, lower cost imaging modalities when imaging is warranted.

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;*

ECRMC selected the integration of Primary Care (1.2) and Obesity Prevention (1.7) because they directly correspond to our organizational goals of improving access to care for our patients and improving population health. These projects will enable us to develop the infrastructure needed to address access to primary care issues and integrate additional preventive care services. Implementing the management of High Cost Imaging (3.2) will allow us to develop the platform to target high cost processes hospital wide to reduce the per capita cost of delivering related stewardship programs and service lines.

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*

In a community the size of the Imperial Valley and a hospital the size of ECRMC, the inter-connectivity of service delivery is ever present. Many of our patients present with similar issues on multiple instances throughout our facilities. It is our intent to couple Project 1.2 and 1.7 to address targeted significant health issues within our patient population by increasing the focus on providing care in outpatient settings and expanding the primary care options. Additionally, our Imaging Department regularly sees individuals who have been referred by one of our primary care clinics. By enhancing clinical pathways and training our staff, we can enhance the efficiency and utilization of imaging modalities and improve overall patient care.

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 year 2020, patients who receive services from ECRMC will have greater access to primary and preventive care which will improve health outcomes, reduce health care costs, and build a healthier community. Specifically, ECRMC's patients will have access to improved coordinated care, in turn decreasing the use of our ED and ultimately decreasing avoidable admissions and readmissions.

**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.*

The health care needs identified in Section 2.1 provide the rationale for our enhanced focus on access to primary care, obesity prevention and imaging resource stewardship. We will address these identified unmet needs by enhancing our ability to identify and treat health conditions, targeting wellness programs and proactively engaging patients in coordinating their care. Additionally, we will develop and streamline standardized processes to connect patients to treatment and community referrals.

With obesity being a significant health issues facing our community, we feel strongly about our pursuit of Project 1.7, Obesity Prevention and Healthier Food Initiative, and how improvements made in our outpatient clinics will directly impact and overlap with our improved access to primary care through Project 1.2. Additionally, Project 3.2 will serve as the framework from which we look to implement enhanced population management principals and standards of care throughout our facility.

The PRIME projects we are undertaking will help improve our ability to provide whole-person care. Furthermore, improving access to primary care, enhancing our focus on obesity prevention and healthy lifestyles, and implementing patient-specific imaging standards will provide the infrastructure improvements needed to spread these concepts to all other care needs of our community through 2020 and beyond.

### 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 PRIME projects we have selected are rooted in our commitment to the communities and patients we serve. In October 2015, hospital leadership sanctioned the formation of our PRIME Projects Task force to plan for the implementation of our PRIME projects. This task force will transition to our "Population Management Council" in April 2016. The task force will be ultimately responsible for overseeing the implementation of the PRIME projects as well as reporting data to DHCS on our expected improvements and long-term vision for sustained success.

Our Board of Directors, medical staff, Administrative Executive Team and recent partnerships with the University of California San Diego Health Care System and Rady's Children's Hospital of San Diego are all fully committed to the success of our PRIME project initiatives.

### 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.*

ECRMC will ensure that internal and external stakeholders, as well as Medi-Cal beneficiaries, have the opportunity to engage in the planning and implementation of the PRIME projects.

In December 2015, ECRMC signed an agreement with the Calexico Heffernan Healthcare System for the provision of primary care services in the city of Calexico. This is an underserved region of our County that has limited access to primary care. Members from its Board of Directors and the community are already participating on our PRIME Projects Task Force and will become members of our Population Management Council upon formalization in April 2016.

We have established and are augmenting relationships with community-based organizations that provide support services to our patients. This includes educational institutions such as San Diego State University. We are also engaging with the Imperial County Health Department and their various task forces that are currently engaged in related programs, such as the Healthy People 2020 initiatives.

We will continue to work with these stakeholders as part of PRIME planning and implementation and will identify additional organizations that we may add to these planning activities in the coming months and years.

ECRMC intends to bring on a PRIME Project Manager who will be responsible for the implementation and continued commitment to the success of our PRIME project. The Project Manager will report to the Senior Director of Quality and Risk Management, who reports to the Chief Medical Officer and Chief Executive Officer.

### 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.*

ECRMC recognizes that in order to improve care delivery and the quality of care, it is important to understand the personal and cultural care needs of our diverse patient population. We have made, and continue to make, a commitment to ensuring that our leaders, providers, and staff reflect the diversity of our patient population. As a result, the care that we deliver not only meets the medical care needs of patients, but the cultural needs as well.

Our commitment to cultural competent care starts with the onboarding process with every new employee hired during staff orientation and continues with annual education and reeducation as needed. We intend to continue these activities and to improve upon them as we implement our PRIME projects.

To support these efforts, we will continue to translate educational materials into our identified threshold languages and will continue to provide real-time access to interpreter services as a complement to our provider's language capabilities, many of whom are bi-lingual. We will also schedule planned events to include periodic health fairs with providers who speak Spanish and provide additional staff trainings on issues related to cultural competence and health disparities.

**3.6 Sustainability.** [No more than 150 words]

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

ECRMC has participated, and will continue to do so in the future, in CMS Quality Improvement Organization-style learning collaboratives. As a result of these experiences and the management of a myriad of elective and regulatory quality improvement requirements, ECRMC feels confident in our ability to sustain PRIME improvements long after PRIME participation has ended by:

- Recruiting provider and staff project champions.
- Engaging providers and staff in the planning, implementation, and management of projects.
- Continuing the provision of Total Quality Management education and theory to practice application via the deployment of internal collaborative type projects.
- Recommitting senior leadership to support the success of this philosophical change in care delivery.
- Relying on data driven decision making to include the use of process, outcome oriented, and balancing measures to achieve goals.
- Utilize PRIME Project Task Force and Administrative Executive Team for project oversight, review and strategic planning
- Engaging our stakeholders as the final quantifiable proof that our program and projects are meeting their needs.

## 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)

***El Centro Regional Medical Center (ECRMC) Project 1.2 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.***

1. *Summarize your approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. (no more than 300 words)*

**Rationale:** Access to care has long proven to be a major challenge for our community. In 2012-13, there was one primary-care physician for every 4,170 Imperial County residents, compared to one for every 1,341 residents statewide. The current care model within ECRMC is not prevention or maintenance focused. The Primary Care redesign project will assist with improving timely primary care access, with a focus on transitioning from chronic disease management to health promotion and prevention.

**Planned Design and Implementation Approach**:

The project design will include 2 tracks for population management within our Outpatient Clinic Population:

1. Prevention track:
    a. Implementation of a primary prevention program targeted at disease prevention and patient education aimed at altering behaviors or lifestyle choices known to cause disease ie. Smoking cessation.
    b. Implementation of a secondary prevention program aimed at detecting pre-pathological changes to control disease progression ie. Mammogram with timely follow up and intervention.

2. Tertiary track: Once a disease has developed and been treated in the acute phase, the program will focus on modification of behaviors that would limit progression of the disease and limit, reduce or eliminate the number of acute care admissions for emergency or inpatient care. (Specific to diseases outlined in

PQI #90). The tertiary track would include identification of "acute care super users" who need additional assistance with management of the disease process and assist them in disease management through the use of promotoras/community health workers/ social workers and referral to community agencies and services. Super user patients would be carefully followed and supported to assist in their transition to disease self-management.

Implementation will include the following:

1. Development of the electronic infrastructure to monitor and track ECRMC's compliance with prevention initiatives.
2. Development of the primary, secondary and tertiary prevention processes using evidence based practice.
3. Development of 24 hour telephone triage system
4. Hiring sufficient number of providers to:
    a. Manage the preventative care needs of the patients
    b. Provide next day visit for acute issues to reduce emergency and inpatient care needs.
    c. Provide follow-up appointments post-discharge from ER or acute care.
    d. Manage the care of "super-user" patients who will need more frequent physician oversight and monitoring of their health condition.
5. Hiring and training of necessary personnel to meet design and role expectations.
6. Development of a quality assurance performance improvement processes to track progress and identify areas for improvement.

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

**Target Population***:* ECRMC's Project 1.2 will cross many departments, lines of service and patient settings. However, our overarching target population will be the Medi-Cal and Medi-Cal Managed Care beneficiaries who present in our outpatient clinics. We expect the target population to be varied due to the range of interventions required for this project as well as the clinical prevention/screening recommendations.

**Vision for Care Delivery**: PRIME will give ECRMC the foundation with which to jumpstart our long-term goal of preventative healthcare management. The outline, rigidity for data reporting and roadmap to implementation, as presented in the appendix, will play a key role in moving our facility forward.

With the enhancements made through the above mentioned design and implementation approach, ECRMC will be able to ensure that those Medi-Cal, and eventually all, patients who are seen in our facilities are receiving enhanced primary care services

focused on health maintenance and prevention. Through participation in Project 1.2, ECRMC envisions; 1) Increasing the provision of recommended preventative health services available to patients, 2) Enhancing patient engagement and disease self-management, 3) Decreasing preventable acute care utilization, and 4) Reducing health disparities for our patients. Transforming clinic settings to a PCMH-based model will allow patients to experience increased access to healthcare through coordinated care teams. Patients will be engaged in their care management and receive appropriate and timely follow-up, helping to decrease over-utilization of the hospital ED, and will improve health outcomes. Lastly, patients will be better managed, improving population health within the community.

*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 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). |

| Check, if applicable | Description of Core Components |
|---|---|
| **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.<br>• 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)). |
| **Applicable** | **1.2.10** Engage patients using care plans, and self-management education, and through involvement in the design and implementation of this project. |

| Check, if applicable | Description of Core Components |
|---|---|
| **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. |

## ☒ 1.7 – Obesity Prevention and Healthier Foods Initiative

**Rationale:** ECRMC serves as a primary care provider for many Imperial County residents' healthcare needs. As referenced in Section 2.1, data indicates that 78% of adults, 29.9% of children ages 2-5, and 41.2% of youth ages 5-20 within our community are overweight or obese. With a focus on preventative care, our hospital is committed to improving our obesity prevention efforts through enhanced services, data tracking and education on the causes and treatments of obesity.

Our planned design and implementation approach includes:

- **Obesity Screening and Referral:** Screen every patient within our outpatient clinics for out-of-range BMI and develop an EMR adaptation to improve the rate of referrals for patients outside of normal ranges. We expect to complete our EMR adaptation and training of staff on these referral processes in DY 11.

- **Patient Tracking**: Develop improved tracking mechanisms for patient follow-up within our EMR in order to ensure proper follow-up occurs and is documented. We expect to implement these EMR improvements and follow-up protocols in DY 11.

- **Nutritional and Physical Counseling:** Explore alternative approaches to nutritional and physical counseling through expanded provider agreements and the potential placement of nutrition personnel in key patient-service settings. Such resources would allow our facilities to provide on-the-spot or appointment based counseling. We expect to begin this exploration in DY 11 and continue expanding patient service opportunities into the future.

- **Hospital Nutrition and Wellness Program:** Improve dietary guidelines within our facility in order to increase access to wholesome, fresh, nutritious foods and improve educational opportunities surrounding healthy lifestyle choices. This will be done in conjunction with our current contractors and through the guidance of the Partnership for a Healthier America's Hospital Heathier Food Initiative. We expect to pursue these improvements beginning in DY 11 and continue throughout the PRIME five-year timeline.

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

**Target Population:** This project will focus in on two key ECRMC populations. For the BMI screening/follow-up and weight assessment and counseling portions, we will target the Medi-Cal and Medi-Cal Managed Care beneficiaries within our two outpatient clinics in the cities of Calexico and El Centro. For the healthier hospital food initiative, we will target all patients, guests and employees who visit our hospital's main campus cafeteria through the implementation of a nutrition and wellness program in line with the Partnership for a Healthier America's Hospital Health Food Initiative.

**Vision for Care Delivery:** The PRIME Obesity Prevention and Healthier Foods Initiative will lay the framework for improved patient service delivery, improved and healthier dietary offerings and overall attitude regarding the fight against obesity within our inpatient and outpatient settings. ECRMC is currently transitioning from illness management care to illness prevention care, with education and data tracking playing a key role. The targeted focus of Project 1.7 will support the long-term vision of ECRMC's improved patient care through hopeful reductions in obesity and overweight levels in our community, and promotion of a healthier lifestyle through food choices and physical activity. We anticipate these reductions coming in part due to the work of our facility to

educate, track, treat and prevent causes of obesity through the PRIME program and beyond.

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

| Check, if applicable | Description of Core Components |
|---|---|
| **Applicable** | **1.7.1** 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** | **1.7.2** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to USPSTF A and B Recommendations. |
| **Applicable** | **1.7.3** Improve access to quality care and decrease disparities in the delivery of preventive services. |
| **Not Applicable** | **1.7.4** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health. |
| **Applicable** | **1.7.5** 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. |
| **Applicable** | **1.7.6** 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** | 1.7.7 Implement a system for performance management that includes ambitious targets and feedback from patients, community partners, front line staff, and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology. |
| **Not Applicable** | **1.7.8** Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts. |
| **Applicable** | **1.7.9** Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs. |
| **Applicable** | **1.7.1**0 Prepare for and implement the Partnership for a Healthier America's Hospital Healthier Food Initiative. |

***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 4.3 – Domain 3: Resource Utilization Efficiency

### ☒ 3.2 – Resource Stewardship: High Cost Imaging

**Rationale**: In 2015, ECRMC conducted 25 MRI scans for patients who came into the ED with complaints of headaches and no neurologic deficits. Upon review it was determined the majority of these cases yielded negative results. It is evident through staff experience and preliminary data pulls that CT and MRI scans have limited cost efficacy when used for patients that present with routine headaches. ECRMC plans to put in place processes to educate and train providers to improve efficiencies of such tests, in return improving patient care and reducing unnecessary expenses.

**Planned Project Design Approach**:

Developing staff training and procedural protocols that will:

- Reduce the number of unnecessary and inappropriate studies; and
- Improve the use of evidence-based, lower cost imaging modalities when imaging is warranted.

**Planned Implementation Approach**:

*Clinical Pathways:* ECRMC will convene a working group to review current clinical workflow around the use of imaging studies. This group will develop common clinical pathways, processes for providers, and standards of care regarding the use of imaging. They will also develop a list of evidence-based, lower cost imaging modalities when imaging is warranted. We expect to begin complete this work in DY 11.

*Care Team Training*: ECRMC will assess the level of education across the care team regarding appropriate use of imaging. We will develop a training program designed to address unnecessary or inappropriate studies. We are currently conducting a needs assessment, development of policies and procedures, and conducting initial staff

training. We will conduct trainings ongoing thereafter as deemed necessary. We expect to complete this training in DY 11 for current staff.

*Quality Improvement*: ECRMC will implement a system for continual rapid cycle improvement and performance feedback. We expect to begin this work in DY 11 and continue such procedures through the PRIME five-year timeline and beyond.

1. *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 for this project are Medi-Cal and Medi-Cal Managed Care beneficiaries who present in the ED and outpatient clinics with symptoms that could indicate the need for the selected imaging studies (e.g. headache, PE, and low-back pain).

**Vision for Care Delivery:** PRIME will place ECRMC in a position to accomplish several key objectives that are central to our ability to provide high-quality, cost-effective care and to transform our health care delivery system. The development of common clinical pathways will furnish providers and staff with the tools required to ensure that the needs of patients are met and that unnecessarily high cost imaging studies are not routinely ordered. Additional improvements lie in the development of the organization's policies and procedures on the use of imaging studies. Implementing new policies and revising existing ones will improve the assessment/ordering process with imaging exams for diagnoses such as headache, PE, and low-back pain. It is important to note that the overall goal is to achieve the best possible care needed for each and every patient. Lastly, providing training to the staff on these processes will include how during the patient interview to put an emphasis on acquiring the necessary information to determine what is and isn't needed for proper diagnosis and treatment. This improvement in staff knowledge will in turn contribute to improved population management, reduced fragmentation of care for patients, and decreased costs to patients and the hospital.

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

| Check, if applicable | Description of Core Components |
|---|---|
| **Applicable** | **3.2.1** Implement an imaging management program, demonstrating engagement of patients in the design and implementation of components of the project. |

| Check, if applicable | Description of Core Components |
|---|---|
| **Not Applicable** | **3.2.2** Program should include identification of top imaging tests whose necessity should be assessed for possible overuse. Criteria for assessment could include:<br>• Frequency and cost of inappropriate/unnecessary imaging:<br>o Appropriate Use: Beginning with state- or nationally-recognized models or guidelines (e.g., American College of Radiology Appropriateness Criteria, American College of Cardiology Appropriate Use Criteria) and incorporating pertinent local factors, programs will set out definitions for appropriateness.<br>o Cost: Programs will identify imaging studies associated with high costs due to high cost per study or high volume across the system.<br>• Unwarranted practice variation within the participating DPHs/DMPHs. Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed.<br>• Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed.<br>• Whether there are established, tested and available evidence-based clinical pathways to guide cost-effective imaging choices. |
| **Applicable** | **3.2.3** Establish standards of care regarding use of imaging, including:<br>• Costs are high and evidence for clinical effectiveness is highly variable or low.<br>• The imaging service is overused compared to evidence-based appropriateness criteria.<br>Lack of evidence of additional value (benefits to cost) compared to other imaging options available to answer the clinical question. |
| **Not Applicable** | **3.2.4** Incorporate cost information into decision making processes:<br>• Develop recommendations as guidelines for provider-patient shared decision conversations in determining an appropriate treatment plan.<br>• Implementation of decision support, evidence-based guidelines and medical criteria to recommend best course of action. |
| **Applicable** | **3.2.5** Provide staff training on project components including implementation of recommendations, and methods for engaging patients in shared decision making as regards to appropriate use of imaging. |
| **Applicable** | **3.2.6** Implement a system for continual rapid cycle improvement and performance feedback that includes patients, front line staff and senior leadership. |

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

| | For DPHs | For DMPHs |
|---|---|---|
| Domain 3 Subtotal # of Selected Projects (Select At Least 1): | | **1** |
| 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 $ 9,060,000
- DY 12 $ 9,060,000
- DY 13 $ 9,060,000
- DY 14 $ 8,154,000
- DY 15 $ 6,930,900

**Total 5-year prime plan incentive amount: $** 42,264,900

## 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.** | Advance PCMH Transformation | 1. Convene a workgroup to perform a gap analysis for NCQA recognition<br>2. Work with EMR vendor to implement workflow and reporting for PCMH<br>3. Develop a Master Schedule for implementation of PCMH Standards with responsibility assigned<br>4. Develop staffing model and position responsibility for PCMH<br>5. Complete/revise policies, documents, and workflows necessary for selected standards and begin review of required reports<br>6. Develop and submit PCMH recognition application<br>7. Develop referral lists for selected diagnosis and individual preventative health metrics<br>8. Develop protocols for assignment of all eligible patients to primary care providers within a medical home model<br>9. Develop protocols for assignments for all complex-care disease specific patients to appropriate staff<br>10. Develop bi-directional communication and referral processes to specialist care, acute care, social and community-based services<br>11. Develop electronic | 1.2 | January 1, 2016 – June 30, 2017 |

| | Proposed Process Measures | Proposed Milestones | Applicable Project Numbers | Process Measure Start Date – End Date |
|---|---|---|---|---|
| | | processes to identify ER visits and admissions in a timely manner when a complex care patient is seen in the hospital setting<br>12. Develop post-ER visit/post-admission response plan protocols for complex care diagnosis<br>13. Conduct a gap analysis to crosswalk HEDIS measures, current EPB preventative and chronic disease management tools, and PRIME requirements<br>14. Create, adopt and implement evidence-based best practice chronic disease management tools not currently in use | | |
| **2.** | Improve access to care | 1. Conduct a gap analysis to determine current staffing needs<br>2. Based on staffing needs budget for necessary positions<br>3. Develop job descriptions for budgeted staff<br>4. Recruit and interview staff<br>5. Hire staff<br>6. Develop a training curriculum for team-based care and PRIME project metrics<br>7. Implement training program for all project and clinic staff<br>8. Develop and implement same-day appointment processes.<br>9. Develop and implement | 1.2 | January 1, 2016 – June 30, 2017 |

| | Proposed Process Measures | Proposed Milestones | Applicable Project Numbers | Process Measure Start Date – End Date |
|---|---|---|---|---|
| | | telephone triage process<br>10. Assign care navigation specialists to address non-clinical elements of the care plan<br>11. Utilize gap analysis to determine most effective enhancements in access to pediatric care<br>12. Collaborate with providers to develop strategy to supplement pediatric primary needs<br>13. Develop, finalize and implement agreements for the provision of expanded outpatient pediatric services<br>14. Utilize gap analysis to determine most effective enhancements in access to primary care<br>15. Expand outpatient clinic hours based on identified need through the gap analysis | | |
| **3.** | Increase primary care provider services | 1. Conduct a gap analysis to determine primary care needs<br>2. Budget for additional primary care providers<br>3. Recruit, hire and train primary care providers | 1.2 | January 1, 2016 – June 30, 2017 |
| **4.** | Build computer infrastructure within existing electronic medical record systems | 1. Complete ECW infrastructure build to capture metric specific specifications and related ICD 10 codes for outpatient metrics<br>2. Complete Midas infrastructure build to capture metric | 1.2 | January 1. 2016 – June 30, 2017 |

| | Proposed Process Measures | Proposed Milestones | Applicable Project Numbers | Process Measure Start Date – End Date |
|---|---|---|---|---|
| | | specifications and related ICD 10 codes for inpatient specific metrics.<br>3. Upgrade ECW to the latest version<br>4. Implement system to support pre-visit planning, point of care delivery, care coordination, population/ panel management activities, patient engagement, operational and strategic decisions including data and monitoring system | | |
| **5.** | Expand IT infrastructure and storage capacity | 1. Budget for expanded technological data capacity<br>2. Purchase computers and phone lines necessary to meet demand for additional data requirements<br>3. Evaluate rental vs. expansion opportunities at current locations | 1.2 | January 1, 2016 – June 30, 2017 |
| **6.** | Accuracy and completeness of REAL and SO/GI data | 1. Conduct a gap analysis of current technological registration infrastructure for SO/GI and REAL data elements<br>2. Build non-existent SO/GI and REAL data metrics as identified by gap analysis<br>3. Identify processes to track compliance with SO/GI and REAL data metric indicators<br>4. Develop and implement process for ongoing validation of SO/GI and REAL data metrics | 1.2 | January 1, 2016 – June 30, 2017 |

| | Proposed Process Measures | Proposed Milestones | Applicable Project Numbers | Process Measure Start Date – End Date |
|---|---|---|---|---|
| **7.** | Quality Management Plan | 1. Develop a system for continual performance feedback and cycle improvement | 1.2 | January 1, 2016 – June 30, 2017 |
| **8.** | Population Management Task Force | 1. Develop key group stakeholders to meet monthly to oversee progress and make recommendations regarding population management<br>2. Develop Population Management Task Force Charter<br>3. Develop goals, objectives and deliverables | 1.2 | January 1, 2016 – June 30, 2016 |