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

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

Marin General 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.

Marin General Hospital (MGH) is located in Greenbrae and serves the County of Marin. Marin County is a relatively healthy county compared to California as a whole but there are subsets of the population that experience negative health outcomes and health disparities.[1]

Physical Health: The most significant health issues facing Marin County include obesity, and chronic conditions such as diabetes and heart disease.

- *Obesity.* An estimated 17.5% of adults are obese (compared to 22.3% in California)[2] and 30.8% are overweight (35.9% in California)[3]
- *Diabetes.* Marin County's estimated prevalence of diabetes is 5.5% (compared to 9.6% in California)[4]
- *Heart Disease.* Marin County has a higher heart disease prevalence (7.6%) than California (6.1%)[5]

Though rates of obesity and diabetes are lower in Marin County than in California, there remains concern about long-term management of chronic conditions. An estimated 61.4% of total healthcare expenditures in the county were for individuals with 6 or more chronic conditions.[6]

Behavioral Health: While Marin County is reported to have an adequate supply of mental health providers[7], residents and stakeholders note challenges in obtaining the full spectrum of mental health care services[8]. Suicide rates in Marin County are higher than the California average (12.8% versus 9.8%),[9] and 19.5% of Marin adults reported

needing treatment for mental health or substance abuse.[10]

Health Disparities: The high cost of living in Marin County creates a significant discrepancy in income between the highest earners and those living in poverty, exacerbating health disparities.

In Marin County, there are four HRSA-designated Health Professional Shortage Areas (HPSAs), and three geographic regions identified as Medically Underserved Areas.[11] These areas correlate with populations with higher poverty rates, and uninsured and underinsured residents.[12]

Coverage and Access: Nearly 20% of the County is insured by Medicaid, increasing to 31.84% in HRSA-designated HPSAs like Marin City and the Canal district.[13] Approximately 8.9% of the population of Marin County is uninsured.[14] Lower income residents have difficulty accessing specialty care services, particularly outpatient services, and many providers who see low-income patients are at capacity.[15]

Aging Population: Marin County's population is older than California, and the percentage greater than 65 is growing.[16] CMS data show Marin County has a higher prevalence of cancer, stroke, and atrial fibrillation when compared to California,[17] and that 16.4% of beneficiaries had 4 or more chronic health conditions.[18]

2.2 Population Served Description. *[No more than 250 words]*
Summarize the demographic make-up of the population included in your hospital's service area, including information about per capita income, age, race, ethnicity, primary language, etc.

The MGH service area includes all of Marin County which has a total population of 260,750. The cities included are: Belvedere, Corte Madera, Fairfax, Larkspur, Mill Valley, Novato, Ross, San Anselmo, San Rafael, Sausalito, Tiburon, and the coastal towns of Stinson Beach, Bolinas, Point Reyes, Inverness, Marshall, and Tomales.

Income: The per capita income is $58,004 while the median household income is $91,529. 19.7% of the population has income below 200% of the federal poverty level (FPL).[19] Among renters, 56% spend 30% or more of household income on rent.[20]

Race/Ethnicity: The population of Marin County is 72.2% White, 16% Latino, 3% African American, 6.4% Asian or Pacific, 1.1% Native American, and 1.3% Other.[21] These data fluctuate by region, for example, 88% of the Canal District is Latino, and 31.33% of Marin City is African American.[22]

Language: The primary language is English. 23.5% of the population report a language other than English is spoken at home, and 4.8% of homes are considered linguistically isolated.[23]

Age*:* The population is older than the state overall, with an average age of 45.1 years (compared to 35.6 statewide).[24] The age breakdown is as follows:
- 0-18 years (20.5%)
- 19-64 years (60.1%)
- 65 and over (19.4%, versus 16.7% in 2010) [25,26]

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.

MGH is the only full-service acute care hospital in Marin County with an ACS Level III Trauma Center and Emergency Department, and Labor and Delivery service with a Level II NICU. MGH opened in 1952, and is a locally owned, not-for-profit hospital, governed by a Board of Directors composed of elected community leaders.

MGH's 235-bed licensed acute facility is owned by the Marin Healthcare District, which includes a network of medical care centers providing a range of services. These facilities include: Cardiovascular Center of Marin, Marin Endocrine Center, Marin Internal Medicine, North Bay Urology, North Marin Internal Medicine, San Rafael Medical Center, Sirona Vascular Center, Tamalpais Internal Medicine, and West Marin Medical Center.

Clinical service departments at the hospital include:
- Inpatient and partial hospitalization/outpatient behavioral health
- Cardiac specialty unit
- Cardiovascular surgery
- Cardiovascular services, cardiac catheterization lab, and electrophysiology lab
- Care coordination (case management and social work)
- Clinical laboratory
- Diagnostic imaging
- Family Birth Center
- Intensive care unit
- Medical and surgical units
- Neurosurgery
- Outpatient infusion center
- Outpatient integrative health and wellness services
- Palliative care
- Pediatric unit and neonatal intensive care unit
- Perioperative services including general, specialty and cardiovascular surgery

- Pharmacy
- Radiation oncology
- Rehabilitation
- Respiratory care
- Spiritual care
- Step-down care unit

In FY 2015, MGH's payer mix was: 44.9% Medicare, 28.7% Medi-Cal, 14.2% commercial insurance, 7.5% capitation, and 4.7% other.

In FY 2015, MGH had 8,774 acute inpatient discharges and 194,107 outpatient visits. The average length of stay for acute care was 4.6 days. Hospital beds had a 48% occupancy rate.

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: Ongoing data collection and measurement is overseen by the Performance Improvement Committee. The primary source of data collection is the electronic medical record (EMR). The quality management department utilizes an Admissions, Discharge, and Transfers data feed from the EMR, OSHPD, and coding data from Health Information Management department. Other onsite data sources include laboratory and pharmacy, and an internal IT department which manages the EMR data input interface. MGH will utilize the same systems of data collection for PRIME projects.

Reporting: The Quality Management Program at MGH can build and run internal reports using data collected in the EMR, and has access to an external team who can build reports. The most commonly utilized tool to share performance data is an A3 form, which provides a summary of performance improvement activities. Dashboards are used to review and monitor departmental data. MGH will utilize this same process of data reporting for PRIME projects.

Monitoring: Data is systematically aggregated and analyzed regularly to provide information to the leadership team. Data is analyzed and compared internally and externally with other sources of information when available. Comparative data is used to determine if there is excessive variability or unacceptable levels of performance. The Performance Improvement Committee reviews all identified indicators and measurements for the hospital at least annually. MGH will utilize this same process of data monitoring for PRIME projects.

Anticipated Barriers: We anticipate two main barriers: staff time for data collection, and collecting data from outside agencies with whom we are partnering. MGH will address these barriers by repurposing existing staff and/or deploying new staff to complete the data reporting. We will invest in developing infrastructure for communication systems to ensure timely two-way communication between entities and we will hire a project manager to oversee data collection, reporting and monitoring.

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 review each entity's overall goals and objectives. This section should also describe how these efforts will evolve over the course of the five years.

3.1 PRIME Project Abstract [No more than 600 words]
  Please summarize the goals and objectives for your 5-year PRIME Plan. Include specific information, including:
1. *Describe the goals* for your 5-year PRIME Plan;*
    <u>Note</u>*:*

    * *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.*

MGH's mission is to provide exceptional health care services in a compassionate, healing environment, with a vision to exceed each community member's highest expectations for quality health care. MGH is embarking on a multi-year plan to become recognized in the North Bay for fostering a safe, healing and caring environment, and for efforts in building healthy communities.

MGH's strategic plan focuses on building a collaborative system of care delivery in the community, and expanding the breadth of services to transform the health care system and create a healthier community. MGH's PRIME goals support delivery system transformation by increasing patient access to high-quality health care, improving the coordination of care, partnering with community members, enhancing the patient experience throughout the continuum of care, and improving patient health outcomes.

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.*

PRIME will enable MGH to pursue several aims central to providing high-quality, compassionate, patient-centered care, including : (1) Improve care management for patients with multiple chronic conditions (MCC) ; (2) Improve and/or maintain the quality of life for those with chronic, advanced and terminal illness (3) Ensure smooth care transitions; (4) Enhance collaboration between community healthcare partners by establishing effective communication systems; (5) Eliminate barriers to care by connecting patients to appropriate resources.

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

The establishment of a Complex Care Management (CCM) program (2.3) and expansion of the Palliative Care (PC) program (2.7) will address population health needs outlined in Section 2.1, ensuring high-quality, patient-centered services are provided throughout the continuum of care. Each project is consistent with MGH's goals of delivery system transformation: collaboration, development, and an improved patient experience. PRIME will allow enhanced care delivery in Marin by creating programs to manage patients with MCC, encouraging greater community partnerships, data flow between organizations, patient access and engagement, and improved population wellness.

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*

To redesign care delivery, both projects 2.3 and 2.7 will require infrastructure development for referral and communication systems in the healthcare network, and the development of educational resources to encourage patient and provider engagement. Each project invites new community partnerships to ensure seamless care transitions between acute and ambulatory settings. Finally, both projects will allow MGH to transform the care delivery system by utilizing evidence-based, innovative healthcare delivery models to improve community health outcomes and quality of life.

To ensure that the projects work in a collaborative, inter-related manner, the following tactics will be used:

- Develop a PRIME Steering Committee including project leaders, executive leadership, performance improvement, community outreach and data staff;

- Hire a PRIME Project Manager; and,
- Develop a PRIME dashboard to ensure project transparency across the organization.

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.

We are eager to realize and expand the results PRIME to other programs and areas of our health system. Our patients with MCC will receive improved, coordinated health care services, which will lead to reduced hospital admissions and readmissions. We hope to see a reduction in health disparities in our community, a stronger network of resources, and improved access to high-quality, effective care. Collaboration between patients, staff, and community partners will ensure consistency of care and competence in practice throughout the community.

Through PRIME, MGH expects to transform the health system at the end of the five years as follows:

- **Clinical**:
  - Greater patient self-management of chronic conditions and fewer avoidable hospitalizations.
- **Population Health**:
  - Expanded use of advanced illness planning, for end-of-life care in comfortable and appropriate care settings.
  - Increased use of prevention, screenings, and standards-of-care to improve outcomes and quality of life.
  - Increased use of care coordination and patient-centered care to improve outcomes and quality of life.
- **Fiscal**:
  - Reduced admission and readmission rates and cost of care due to focused management of patients with chronic illnesses.

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

We believe in designing care systems by listening to the community needs. The planned projects enable MGH to provide comprehensive and coordinated services to address the health needs identified in Section 2.1. A higher rate of MGH patients are insured by Medi-Cal (28.7%) compared to overall county rates (19.5%)[27], which underscores the importance of improving chronic disease management and coordination of services for these patients throughout the continuum of care.

MGH will address the significant local health needs, outlined in section 2.1, including access to care, chronic disease management, and needs of an aging population. Due to the prevalence of diabetes and other chronic conditions in our community, MGH has selected projects that improve quality of care for patients suffering from chronic illnesses. MGH plans to address the community need in obtaining access to outpatient care through projects focused on care coordination.

By developing CCM and ambulatory PC programs tailored for high-risk, high-utilizing patients, we will be able to expand the scope and reach of our services to focus on the unique needs of the Medi-Cal population, whom, due to factors like coverage limitations, socioeconomic and geographic barriers, may not fully engage with healthcare services. PRIME will provide MGH with the resources to bridge the gap between acute and ambulatory services, allowing for greater flow of information, better patient outcomes, cost-effective care, and a reduction in preventable hospitalizations.

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).

We selected our projects with MGH's strategic plan in mind, in order to encourage successful implementation for each of the programs, and successful transformation of the healthcare system. The Performance Improvement Committee and Quality Management Department at MGH will be directly involved with the governance and maintenance of PRIME projects, as these entities are central for data collection and monitoring. We plan to provide regular reports to executive leadership about the programs, including outcomes data. This data will be used to monitor PRIME implementation progress, and to fine-tune our projects over time.

MGH will establish an internal steering committee comprised of leadership and care team members to provide input for the design, workflows, and implementation of the

PRIME projects. Additionally, we will create a PRIME Advisory Committee (PAC), comprised of internal and external providers, community members, and patients. The PAC will be responsible for overseeing the design of the programs initially, and for providing feedback at regular intervals during implementation.

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.

We will connect with key stakeholders in the county in order to outline a network of providers and care teams, determine gaps in communication and referral systems, and plan successful implementation for our new programs. First, we will reach out to local care providers in the community, such as primary care, specialty care, clinics such as Marin Community Clinic, skilled nursing facilities, and other agencies in order to establish a care network. Members from these groups, as well as MGH team members, community members, and patients will be invited to participate in the PAC so their voices can be heard in the design, implementation and on-going work of PRIME. The PAC will meet monthly through the initial planning and design phases of the projects.

We plan to hold a focus group in 2016 to request input from community members and prospective patients about needs they may have surrounding chronic disease management and palliative care. This information will be incorporated into the design and implementation of the programs.

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.

MGH has a history of addressing the unique cultural and language needs of each patient it serves. Currently, MGH employs staff that are also certified as translators, and offers access to real-time translation phone line and sign-language translation services. MGH offers many health education materials in the preferred language of the patient. MGH also provides a range of different complementary healthcare services to assist patients with healing beyond typical Western medicine methods, including integrative medicine practices and spiritual care services.

In the development of the two proposed projects, MGH plans to increase the availability of and access to culturally appropriate resources for both of our new outpatient case

management and palliative care programs. We plan to hire staff with prior experience working with and tailoring services to a diverse population. We will prioritize patient-centered care, which includes but is not limited to, conducting learning and health literacy assessments, developing education materials appropriate for a broad range of clients, utilizing telehealth systems to eliminate geographic or transportation barriers, conducting ongoing staff trainings on cultural competence, providing health information in the preferred language of the patient, and providing access to interpretation services in each of the programs.

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.

As stated in section 3.3, PRIME metrics will be reported to the executive level of the organization. With our Performance Improvement Committee and Quality Management Programs, we plan to implement a robust and ongoing system for monitoring PRIME data in order to get consistent feedback for our progress, to be sustained beyond PRIME participation.

We will also incorporate information gathered in the PRIME learning collaborative, and conduct rapid-cycle improvements to fine-tune our programs. The infrastructure, data capacity, and quality improvement processes that we build under PRIME will enable us to continue these efforts beyond PRIME participation. Involving staff at all levels of the organization, and networking with community stakeholders in the design and implementation of PRIME will ensure the programs are in line with community needs, and help us maintain the commitment to these efforts beyond the five-year program.

Section 4: Project Selection

The PRIME Projects are organized into three Domains:
- Domain 1: Outpatient Delivery System Transformation and Prevention
- Domain 2: Targeted High Risk or High Cost Populations
- Domain 3: Resource Utilization Efficiency

The PRIME program will provide incentive payments to participating entities that commit to implementing 5-year projects within the PRIME domains and as further described in *Attachment II -- PRIME Program Funding and Mechanics Protocol.* The required set of core metrics for each project is outlined in *Attachment Q: PRIME Projects and Metrics*

Protocol. The purpose of this section is for applicants to indicate which projects they will implement and to describe the approaches to implementation.

Selections must comply with the requirements of the STCs and the Attachments Q and II delineating the PRIME program protocols.

Designated Public Hospitals (DPHs) are required to implement projects from all three Domains. DPHs must select at least nine projects, of which six are specifically required:
- Select at least four projects from Domain 1 (Projects 1.1, 1.2, and 1.3 are required);
- Select at least four projects from Domain 2 (Projects 2.1, 2.2, and 2.3 are required); and,
- Select at least one project from Domain 3.

District/Municipal Public Hospitals (DMPHs) are required to select at least one project to implement. DMPHs may select their project(s) from any of the three Domains.

Instructions

For Sections 4.1 - 4.3, click the box(es) that correspond to the project(s) you will undertake. In addition, click the boxes that correspond to the core components you will adhere to in order to achieve the objectives of the project. Note that core components selected are not required; they are meant to guide project execution and serve as recommendations only.

Answer all of the questions below for each selected project. Provide narrative responses in the spaces marked *"[Insert response here]":*

1. *Summarize your approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words]*
2. *Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]*
3. **For DMPHs (as applicable),** *indicate which project(s) your entity is selecting that will require infrastructure-building process measures and complete the supplemental document (Appendix) to identify and describe your proposed process measures.*

   For DMPHs requiring infrastructure building metrics that are approved in the Prime Project Plan, 75% of PRIME funding for DY 11 will be based on the achievement of the approved DY 11 infrastructure building metrics through the final year-end report. Up to 40% of the total PRIME funding for DY12 will be based on the achievement of the approved DY 12 infrastructure building metrics

through the mid-year and final year-end report. The proposed Process Measures should meet the following criteria:

- *Specific*
- *Measurable: Must be able to demonstrate progress throughout the duration of the process metric measurement period.*
- *Evidence-based: Measures should have a strong evidence-base that can linked process to outcomes.*

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

☒ 2.3 – Complex Care Management for High Risk Medical Populations (required for DPHs)

Marin General (DMPH) Project 2.3 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: Section 2.1 data demonstrates that chronic disease management is an important health issue for Marin County. Many MGH patients with Medi-Cal have multiple chronic conditions. As noted in Section 2.1, 61.4% of county healthcare expenditures are for individuals with 6 or more chronic conditions[28]. MGH believes our population could best be served by a CCM program to address their complex healthcare needs.

Planned Design and Implementation Approach:

- *CCM Task Force:* Create a CCM task force of internal and external stakeholders to oversee planning and implementation of the CCM program. This will start in DY11 and continue through implementation.
- *CCM Program Development*: Research nationally recognized CCM program methodologies, and select and build a CCM model that best meets our healthcare system needs. Research will begin in DY11, with model selection in DY12.

- *Staffing*: Conduct a workforce gap analysis to identify staffing needs, and recruit, hire and train staff. Each patient will be assigned a care navigator. We will begin this in DY11.

- *Community Network Development:* Strengthen communication within our healthcare network by partnering with community providers, clinics, and agencies. We will identify a set of essential resources for patients with chronic medical conditions. This will begin in DY11.

- *Referral System:* Work with IT, Quality, and Health Information Management to create a CCM referral infrastructure in our EMR. Patients will be referred by internal and external providers, and identified by MGH care coordinators and discharge planners on an ongoing basis. This will begin in DY11.

- *Provider and Patient Engagement:* Develop provider and patient education tools and resources for chronic disease management and patient self-management. We will begin work on this in DY12.

- *Telehealth:* Install HIPAA-compliant video conferencing equipment to expand the reach of CCM. We will begin researching infrastructure in DY11. DY12 will involve setting up service equipment.

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

Target Population: This project allows MGH to use a set of evidence-based parameters to identify the population at highest risk for readmissions and complications related to chronic disease. The target population is adult Medi-Cal patients with chronic conditions. To address county public health priorities, we will begin with a cohort of patients who have diabetes and 3 or more other chronic conditions, later extending the program to other Medi-Cal patients with 4 or more chronic conditions.

Vision for Care Delivery: A CCM program will enable MGH to provide targeted, culturally-appropriate patient-centered care to the most vulnerable members of the community. Through access to additional supportive services, the program will decrease unnecessary emergency department visits and avoidable readmissions/admissions amongst high-risk patients. By developing a care management team which utilizes community health outreach specialists, MGH's program aims to empower the patient to self-advocate and self-navigate the healthcare system which will lead to improved outcomes and increased patient satisfaction and participation in their healthcare.

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

Check, if applicable	Description of Core Components
Applicable	**2.3.1** Develop a complex care management program at one site or with one defined cohort, or expand an existing program from a pilot site to all sites or to additional high-risk groups and demonstrate engagement of patients in the design and implementation of the project.
Applicable	**2.3.2** Utilize at least one nationally recognized complex care management program methodology.
Applicable	**2.3.3** Identify target population(s) and develop program inclusion criteria based on quantitative and qualitative data (e.g., acute care utilization, lack of primary care utilization, number of high-risk medical mental or SUD conditions, polypharmacy, primary care input, functional status, patient activation, social support or other factors). Include patient factors associated with a higher probability of being impacted by complex care management.
Applicable	**2.3.4** Conduct a qualitative assessment of high-risk, high-utilizing patients.
Applicable	**2.3.5** Establish data analytics systems using clinical data sources (e.g., EHR, registries), utilization and other available data (e.g., financial, health plan, zip codes), to enable identification of high-risk/rising risk patients for targeted complex care management interventions, including ability to stratify impact by race, ethnicity and language.
Applicable	**2.3.6** Develop a multi-disciplinary care team, to which each participant is assigned, that is tailored to the target population and whose interventions are tiered according to patient level of risk.
Applicable	**2.3.7** Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets.
Applicable	**2.3.8** Implement evidence-based practice guidelines to address risk factor reduction (smoking cessation/immunization/substance abuse identification and referral to treatment/depression and other behavioral health screening, etc.) as well as to ensure appropriate management of chronic diseases: • Use standardized patient assessment and evaluation tools (may be developed locally, or adopted/adapted from nationally recognized sources). Use educational materials that are consistent with cultural, linguistic and health literacy needs of the target population.
Applicable	**2.3.9** Ensure systems and culturally appropriate team members (e.g. community health worker, health navigator or promotora) are in place to support system navigation and provide patient linkage to appropriate physical health, mental health, SUD and social services.

Check, if applicable	Description of Core Components
	Ensure follow-up and retention in care to those services, which are under DPH/DMPH authority, and promote adherence to medications.
Applicable	**2.3.10** Implement technology-enabled data systems to support patients and care teams throughout the care management program including patient identification, pre-visit planning, point-of-care delivery, care plan development and population/panel management activities.
Applicable	**2.3.11** Implement a data-driven system for rapid cycle improvement and performance feedback to address quality and safety of patient care, which includes patients, front line staff and senior leadership.

☒ 2.7 – Comprehensive Advanced Illness Planning and Care

Marin General (DMPH) Project 2.7 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: MGH selected this project because of our aging population with advanced, chronic, and/or terminal illness, and lack of available palliative care (PC) services. Nearly 20% of the county population is age 65 and older, which is 5% increase since 2010.[29] In 2015, the MGH PC team conducted 658 consults. 32.3% of these PC consults were discharged without receiving follow-up in an ambulatory PC program, suggesting a need to create additional services for the community.

Planned Design and Implementation Approach:

- *PC Task Force*: We will create a PC Advisory Task Force to provide leadership on the design and implementation of the project. Task Force members will be selected and convene in DY11.

- *Education and Training/Certification:* MGH will assess the level of PC education across the hospital care team. We will provide education and training for the clinical staff through affiliation with UCSF Palliative Care Quality Network and other recognized PC training programs. Education will extend to patients and families as appropriate. Work in DY 11 will begin with a needs assessment. Work in DY 12 will include education and training.

- *Referral Process:* MGH will develop a robust PC referral process for in-house clinical providers and all ancillary services. After developing a PC program in the ambulatory setting, we will expand the referral process to collaborate with community partners. We expect the in-house referral process to start in DY 11 and be completed in DY 12. In DY 12 we will establish a referral system for the ambulatory setting including community partnerships.

- *Telehealth for follow up/home visits after discharge:* In conjunction with Project 2.3, HIPAA-compliant video conferencing equipment will be installed in order to expand the reach of PC services. In DY11 we will begin to assess infrastructure needs. DY12 will involve setting up service equipment.

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 adult Medi-Cal patients with advanced or terminal illnesses such as Stage 4 Cancer, advanced organ failure in ESRD, ESLD, Class IV CHF, COPD, dementia, and/or neurodegenerative disease meeting the criteria for referral who agree to participate in PC services. We intend to begin PC work in the inpatient care setting, and then following a gap analysis, extend PC services to the ambulatory setting.

Vision for Care Delivery: By expanding PC services, MGH will offer an essential support to our patients and their families and improve their quality of life. Our PC Program will increase access to care for symptom management, advance care planning, and engagement of the patient around shared medical decision-making and establishing care goals. The enhanced social, emotional and spiritual support provided by the PC service will positively impact overall chronic disease management as well as improve quality of life for patients and families served. By partnering with community and provider resources, the PC service will support improved communication and continuity of care. Providing training to the care team related to the importance of PC screening and patient and family/caregiver engagement will contribute to improved population management and reduce fragmentation of care for patients. The expected reduction in emergency department visits and hospitalizations will free resources for

new services that promote innovative advanced illness management strategies and programs within our system and the community.

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

Check, if applicable	Description of Core Components
Applicable	**2.7.1** Establish or expand both ambulatory and inpatient palliative care (PC) programs that provide: • Total, active and individualized patient care, including comprehensive assessment, inter-professional care planning and care delivery. • Support for the family. • Interdisciplinary teamwork. • Effective communication (culturally and linguistically appropriate). • Effective coordination. • Attention to quality of life and reduction of symptom burden. • Engagement of patients and families in the design and implementation of the program.
Applicable	**2.7.2** Develop criteria for program inclusion based on quantitative and qualitative data: • Establish data analytics systems to capture program inclusion criteria data elements.
Applicable	**2.7.3** Implement, expand, or link with, a Primary Palliative Care training program for front-line clinicians to receive basic PC training, including advanced care planning, as well as supervision from specialty PC clinicians. Assure key palliative care competencies for primary care providers by mandating a minimum of 8 hours of training for front line clinicians in communication skills and symptom management.
Applicable	**2.7.4** Develop comprehensive advance care planning processes and improve implementation of advance care planning with advanced illness patients.
Applicable	**2.7.5** Establish care goals consistent with patient and family preferences, and develop protocols for management/control of pain and other symptoms in patients with advanced illness, including a holistic approach that includes spiritual and emotional needs.
Not Applicable	**2.7.6** Improve completion of Physician Orders for Life-Sustaining Treatment (POLST) with eligible patients and participate in the state-wide POLST registry.

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

Please complete the summary chart:

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

Section 5: Project Metrics and Reporting Requirements

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

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

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

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

Section 6: Data Integrity

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

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

Section 7: Learning Collaborative Participation

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

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

Section 8: Program Incentive Payment Amount

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

Total computable 5-year PRIME plan incentive payment amount for:
- DY 11 $ ~~2,444,837.00~~2,440,000
- DY 12 $ ~~2,444,837.00~~$2,440,000
- DY 13 $ ~~2,444,837.00~~$2,440,000
- DY 14 $ ~~2,200,354.00~~$2,196,000
- DY 15 $ ~~1,870,301.00~~$1,866,600

Total 5-year prime plan incentive amount: $ ~~11,405,167.00~~$11,382,600

Section 9: Health Plan Contract (DPHs Only)

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

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

Section 10: Certification

DPHs are required to commit to contracting with at least one MCP in the MCP service area that they operate using APMs by January 1, 2018.

☒ 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.	Develop workforce strategy for CCM and PC Programs	• Conduct workforce gap analysis to determine staff hiring, redeployment and training needs • Develop a workforce plan • Draft job descriptions based on gap analysis results (e.g. for Chronic Condition Patient Navigator, PC Patient Navigator) • Work with Human Resources to recruit for position(s) • Hire positions • Train new team members	2.3, 2.7	January 1, 2016 – December 31, 2016
2.	Define and identify target population	• Convene project teams with Data/Documentation staff • Discuss metrics and patient factors associated with a higher probability of being impacted by program • Define target populations • Identify target populations	2.3, 2.7	January 1, 2016 –June 30, 2016
3.	Implement system for continual performance feedback and rapid cycle improvement	• Convene a multidisciplinary work group to design and implement a system for continual performance feedback and rapid cycle improvement	2.3, 2.7	July 1, 2016- December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Conduct an analysis of current performance feedback and rapid cycle improvement initiatives • Develop process to provide feedback to care teams around preventive service benchmarks and incentivize QI efforts • Development of patient and staff surveys for targeted feedback of service design and implementation • Design workflows and documentation to reinforce patient engagement in plans of care • Develop and implement performance feedback and rapid cycle improvement initiatives policies and procedures • Implement performance feedback and rapid cycle improvement process		
4.	Creation or expansion of data reporting systems for PRIME	• Conduct a needs assessment to determine data collection needs	2.3, 2.7	January 1, 2016 – December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Conduct a gap analysis of current data system and its shortcomings • Identify gaps in current EMR and potential changes needed to support • Identify resource/staffing requirements needed extract and analyze data • Implement changes necessary to EMR to support data needs • Implement changes necessary to data analytics system/support to support data extraction and analysis • Identify metrics needed for performance monitoring • Work with IT to ensure proper metrics for project are capture and tracked with regards to improvements • Build data elements within EHRs • Train clinical staff on clinical documentation needed to capture data elements • Report to identify patients with Medi-Cal and eligible conditions real time		

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Develop report template to track target population • Build reports • Establish reporting schedule and distribution process		
5.	Develop and implement process to Secure patients and referral sources	• Identify patients who would qualify/benefit from programs/projects through hospital data • Identify potential referral sources in the community for target populations • Market to potential referral sources • Recruit patients to programs/projects	2.3, 2.7	January 1, 2016- December 31, 2016
6.	Development of a HIPAA-compliant telehealth program between MGH and external hub sites	• Conduct a needs assessment to determine patients' barriers to in-person care for CCM and PC (e.g. transportation) and preferences around care (e.g. longer clinic hours) • Partner with at least one health professional shortage area to become a hub site for telehealth services. • Review reimbursement billing and procedures for telehealth program • Research HIPAA – compliant technology and equipment required to create "hub site"	2.3, 2.7	January 1, 2016 – June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Develop plan to create educational materials for online health care and education • Install hub site equipment and train staff at hub site location • Initiate remote patient visits between MGH and patient at hub site		
7.	Develop transitions of care process for CCM and PC programs	• Conduct gap analysis to review current workflow around transitions of care • Update existing or develop new standardized workflows for care transitions • Develop protocols and procedures for care transitions • Train staff on care transition protocol and procedures	2.3, 2.7	July 1, 2016 – June 30, 2017
8.	Develop and Implement a Community Network Engagement Strategy	• Identify community based providers with whom to partner • Conduct a gap analysis of educational materials to identify needs • Develop educational materials for community based providers about care management services • Distribute educational materials to community based providers. • Work with community based providers to	2.3, 2.7	January 1, 2016- December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		develop a referral process		
9.	Establish CCM Task Force and Identify Community Partners to Engage	• Identify internal team members for CCM task force • Identify external team members for CCM task force • Convene CCM Task Force • Schedule a regular meeting with community partners to build external relationships related to the CCM program	2.3	January 1, 2016 – June 30, 2016
10.	Research and select CCM program for patients with multiple chronic conditions	• Conduct a needs assessment to determine community needs for CCM program for patients with 4 more chronic conditions • Research and select a nationally-recognized complex care management program methodology that meets community needs	2.3	January 1, 2016 – December 31, 2016
11.	Develop a risk stratification tool to identify patients at risk for re-admission for care transitions program	• Perform an evidenced-based literature search to identify validated tools • Develop and implement a process high risk (screening tool) including utilization of data and information technology, to reliably	2.3	January 1, 2016 – December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		identify hospitalized patients at high-risk for readmission • Implement high risk screening tool to identify patients at risk for readmission • Train and educate staff on high risk screening tool to identify patients at risk for readmission • Investigate system-specific root causes/risk factors for readmission and develop or identify evidence based interventions to address these problems		
12.	Conduct a qualitative assessment of high-risk, high-utilizing patients	• Convene a workgroup with a background in qualitative research and needs of high-risk utilizing patients • Develop a survey tool to assess the needs and utilization patterns of high risk, high-utilizing patients • Develop patient surveys for targeted feedback of service design and implementation • Survey sample of patient population • Analyze survey results • Design workflows and documentation to reinforce patient engagement in plans of care	2.3	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Incorporate findings into strategy to better manage this population		
13.	Development and deployment of clinical and staff education on complex care management model	• Convene a workgroup to conduct a needs assessment, research evidence based practice guidelines, best practices and make recommendations on an approach • Develop curricula modules • Schedule and conduct trainings • Assess effectiveness of trainings	2.3	January 1, 2016- June 30, 2017
14.	Development of a multi-disciplinary complex care management team, to which each participant is assigned, that is tailored to the target population and whose interventions are tiered according to patient level of risk	• Assess current needs of target population and identify types of staff that can address those needs • Develop job descriptions and defined duties for each team member • Recruit and hire for each position • Design continual training for team members on care model • Develop policies and/or protocols that enable team members to practice at the top of their license	2.3	January 1, 2016- December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Develop process to assign patients to members of care team based on level of risk		
15.	Establish PC Task Force and Identify Community Partners to Engage	• Identify internal team members for PC task force • Identify external team members for PC task force • Convene PC Task Force • Develop mission, roles and responsibilities • Schedule a regular meeting schedule with community partners to build external relationships related to the PC program	2.7	January 1, 2016 – June 30, 2016
16.	Research and select a PC program model and develop/identify PC resources	• Conduct a needs assessment to determine community needs for PC program for patients chronic, advanced, or terminal illness • Research and select nationally-recognized PC program methodology that meets community needs • Identify PC resource needs • Review current PC website and education materials for context, accessibility, links to community based partners, and PC	2.7	January 1, 2016- December 31, June 30, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		related resource material • Develop a PC fact sheet • Distribute to community based partners and providers		
17.	Develop and identify Palliative Care resources	• Identify PC resource needs • Review current PC website and education materials for context, accessibility, links to community based partners, and PC related resource material • Develop a PC fact sheet • Distribute to community based partners and providers	2.7	January 1, 2016 – December 30, 2016
18.	Develop a PC referral process and coordinate with community hospice partners	• Review literature for referral best practices • Identify gaps in existing PC referral process • Assess the level of PC education across the hospital care team regarding the existing internal referral process, as well as referral to ambulatory services after discharge. • Based on gaps and best practices, develop referral process • Train staff on new referral process	2.7	January 1, 2016 – December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Pilot referral process in outpatient setting • Implement referral process in outpatient setting • Identify potential Hospice program partners • Develop communication and referral processes with Hospice programs • Work with hospice staff to track patients who expire with less than 3 days on hospice		
19.	Develop a comprehensive advance care planning process	• Review literature around advanced care planning best practices • Develop protocols for advanced care planning • Develop advance care planning tools • Develop training modules on advance care planning • Train staff on modules and protocols • Implement advance care planning process • Develop policies and procedures for documentation of advance care planning preferences in EMR • Train palliative care staff to submit completed POLST to statewide registry	2.7	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
20.	~~Coordinate and partner with Hospice programs~~	• ~~Identify potential Hospice program partners~~ • ~~Develop communication and referral processes with Hospice programs~~ • ~~Work with hospice staff to track patients who expire with less than 3 days on hospice~~	~~2.7~~	~~January 1, 2016- December 31, 2016~~
21.	Educate and Train Hospital Staff and Patients about PC	• Develop a survey to assess hospital staff and patients PC education and training needs • Review PC training programs • Select PC training program(s) based on hospital staff and patient educational needs • Send staff to training program Offer educational opportunities to patients	2.7	July 1, 2016 – June 30, 2017

Appendix- Citations

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9. University of Missouri, Center for Applied Research and Environmental Systems, California Department of Public Health, Public Use Data 2010-2012

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19. US Census Bureau, American Community Survey 5-year Estimates 2009-2013

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