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

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

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General Instructions

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

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

Scoring

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

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

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

Section 1: PRIME Participating Entity Information

Health Care System/Hospital Name

Oak Valley Hospital District

Health Care System Designation(DPH or DMPH)

DMPH

Section 2: Organizational and Community Landscape

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

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

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

Oak Valley Hospital District (OVHD) is located in Oakdale, a city of about 22,000 people situated in the Central Valley. The healthcare needs and disparities of the community are summarized below.

Coverage: The US Census Bureau estimates the Stanislaus County population reached a new peak of 531,997 in 2015. According to the Stanislaus County Health Services Agency, the expansion of the Affordable Care Act increased Medi-Cal covered lives to 217,039 during this same period. Despite 41% of county residents now covered through Medi-Cal, the provider workforce has not expanded to meet this increased demand. In addition, migrant farm and packing plant workers place a hidden burden on the local health care system during certain periods of the year. The four OVHD community health clinics are all located in Primary Care Shortage Areas (PCSA) designated by the California Healthcare Workforce Policy Commission. For example, the Oakdale-Riverbank PCSA has a primary care resident to physician ratio of 3,172:1 which when compared to the California average of 1,294:1 demonstrates the acute need for improved primary care programs at the local community level. The shortage of primary care providers has resulted in delays for patient appointments, increased in-clinic wait times and expanded utilization of the hospital emergency department for conditions more appropriately treated in a primary care setting.

Health Disparities: In 2013/2014, Stanislaus County reported high rates of anxiety, depression (both one in six), and a 30.2% increase in suicide from 2005. Alcohol and tobacco use has been reported in residents of all ages. Depression and substance abuse are reported to be higher in Non-Latinos than Latinos, and males have a higher rate than females for hospitalizations related to substance abuse. Improved access to primary care where prevention screens and interventions will be offered will lead to early identification, treatment and/or referral for these conditions which will positively impact community health status.

Physical Health: The major cause of death in Stanislaus County (2010-2012) was heart disease. According to the 2013 Stanislaus County Community Health Needs Assessment, heart disease is the third most common primary cause of local hospitalization, with an average annual cost of $980,629,089. Hypertension, a major risk factor for cardiac disease, was the 13th most common cause of hospitalizations in the county (2008-2010). An enhanced primary care service model will enable earlier diagnoses and improved treatment for patients with chronic illnesses including cardiac disease.

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.

OVHD serves a population which primarily earns its living from the agricultural products industry. Typical employers include dairy farms, crop producers and packing plants which process and ship agricultural products throughout the world. A wide range of businesses and government employers support the agricultural economy. As a result, the OVHD population tends to be poorer, less educated and with lower health status compared to California as a whole.

Income: Between 2010-2012, per capita income in Stanislaus County ($20,808) was 37% lower than the California average of $28,576, and median household income was $44,400 in comparison to $59,368 for California. Comparatively lower per capita and median household incomes reflect earnings derived from an agricultural economy. Poverty and its associated concerns is a significant local factor: 15.4% of the population subsist at or below the federal poverty level (FPL) and 34% live with incomes at or below 200% of the FPL.

Age: 66.9% of the population in Oakdale is under the age of 44. See Table 1 in Appendix A for population details based on the 2010 US Census.

Race/Ethnicity/Primary Language: Based on 2010 census data, Oakdale is:

- 80.1% White
- 26.1% Hispanic

- 4.1% two or more races
- 2.2% Asian
- 1% American Indian and Alaska Native
- 0.8% Black or African American
- 0.2% Native Hawaiian or Pacific Islander.

The 2015 Oak Valley Community Health Needs Assessment indicated that 59.3% of Stanislaus County households speak English only, 31.5% speak Spanish, 3% speak an Asian language, 4.1% speak an Indo-European language and 2.1% speak other languages.

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.

Oak Valley Hospital District is an integrated, full service public hospital created in 1973 to serve rural residents by providing access to high quality health care services. OVHD consists of a 35 bed general acute care hospital including a 5 bed ICU, 24 medical-surgical beds, basic emergency department and many outpatient services. The hospital district has a 115 bed distinct part SNF which allows an integrated approach to care transitions. OVHD also provides ambulance services, rural health clinics, a women's health clinic and an occupational health program.

OVHD operates four federally certified rural health clinics located in the communities of Oakdale, Waterford, Riverbank and Escalon. These clinics provide essential access to primary, preventative and chronic care services for local residents. The clinics also offer specialty services: prenatal, pediatrics, otolaryngology, gastroenterology, and soon cardiology. A total of 12 physicians, 8 nurse practitioners and 2 physician assistants comprise the clinical staff of these four clinics. Two clinics are open seven days per week and all four rural health clinics will serve as the core platform for program expansion under PRIME.

Based on Net Revenue reported in the filed 2014-2015 OSHPD Annual Financial Disclosure Report, OVHD overall payer mix was:

Medicare	24.16%
Medi-Cal	47.39%
Commercial	27.8%
Other Indigent	0.65%

Of important note: Medi-Cal outpatient net revenue accounted for 33.94% of total net revenue. This demonstrates the significant community role performed by the OVHD rural health clinics.

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: OVHD has recently implemented an electronic health record (eHR) in all four rural health clinics. Workflows in clinics are designed to register, room, treat and discharge patients in a timely fashion. Data are captured and entered into the eHR during all stages of the patient visit. These data are accessible 24/7 to medical providers and appropriate clinic personnel. This same eHR system will support PRIME efforts around data collection.

Reporting: The eHR is augmented by powerful data extraction software that can produce reports used to establish baseline data for PRIME reporting metrics. Software applications are also available to create dashboards useful for monitoring key metrics.

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

Potential Barriers: The hospital's information system is capable of producing standardized reports, some of which contain data useful to project metric reporting. However, it is clear that there are limitations with these standard reports and additional special reports will be needed to satisfy project requirements. Additionally, the small size of our Information Technology (IT) Department creates resource issues. To address both of these potential barriers, a newly retained project manager with an extensive IT background will have responsibility for defining data parameters and reporting structures necessary to meet PRIME project reporting requirements. The project manager will work directly with the software vendor to remove obstacles to data capture, and enable full, timely reporting on all PRIME metrics.

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.*

A goal of OVHD's is to engage patients, providers and other stakeholders in the development and implementation of workflows, processes and other changes crucial to PCMH transformation. The desired outcome of this goal is that the patient centered model will enable new methods to better address the needs of each individual patient.

A long-term goal of OVHD is to improve clinical efficiency and primary care patient management, which will be accomplished through further introduction of evidence based medicine, data monitoring and new systems stemming from the PCMH model.

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.*

   OVHD has two strategic aims:1) improve identification, treatment and monitoring of primary care patients with chronic illnesses; and 2) restructure clinic patient management to improve access, the patient experience and, ultimately, primary care patient outcomes.

   To improve identification, treatment and monitoring of patients with chronic illness, OVHD will modify methods for early diagnosis, intervention and on-going management using evidence based practices. Dedicated care coordinators will assist clinicians to assure patients benefit through improved communication of critical issues. Improved patient communication will also secure improved patient access when needs dictate prompt intervention due to changes in a patient's health status.

   Planned changes to clinic management include adoption of a team approach with defined role expansion focused on targeting the chronic disease patient population. New data capture and monitoring efforts, combined with frequent dashboard presentations for clinical teams enable improvements to patient screening tools and techniques. These tools along with an increased focus on patient cultural considerations, prevention and health improvement, patient medication management, specialty referral, patient engagement through a care coordinator and other measures defined through implementation combine to enrich the patient's clinic experience.

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;*

   Specific aims described in section 3.1.2 above are best addressed through the ambulatory care redesign and patient safety in the ambulatory setting projects. Projects 1.2 and 1.4 have a natural synergy when applied within the rural health clinic setting allowing OVHD to remain focused on the two strategic aims of improving the identification, treatment and monitoring of primary care patients with chronic illnesses through the use of the PCMH approach and improving primary care patient outcomes.

4. *If more than one project is selected, describe how the projects will inter-relate to achieve system transformation (not applicable if only one project is selected); and*

   The redesign of four OVHD rural health clinics, with a specific focus on management of chronic health conditions, modifies the organization of local primary care delivery. Project 1.2 leads to changes which increase access to care providers, promote prevention, enable earlier diagnosis and treatment and improve management for patients with chronic conditions. Project 1.4 targets managing patients on persistent medications - often those with chronic conditions and abnormal test results. Although not limited to chronic illness patients, abnormal test results are common amongst this group. Thus, the first project addresses the overall OVHD primary care delivery structure while the second project aims to address two key issues in management of chronic illness patients. The inter-relatedness of these two projects will help increase access to primary care, lead to reduced hospitalizations, lower costs and improve the patient experience.

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.*

OVHD envisions significant improvements to the patient primary care experience through implementation of the PCMH model. Clinic care will become patient centered while also increasingly data and evidence driven. PRIME enables OVHD to build systems necessary to establish a modified primary care delivery platform through stakeholder engagement in the redesign process. These changes will specifically target improvements to population health, quality care and ultimately play a significant role in overall health care delivery cost reduction. Improved access to primary care clinics will also reduce emergency department utilization for conditions better treated by primary care providers and dedicated rural health clinic teams. The net effect is a reduced cost per capita for overall health service delivery.

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.

OVHD and Stanislaus County have both conducted community health needs assessments which identified access to care as the number one concern of local residents. Limited primary care access has led to longer primary care appointment wait times, less timely diagnosis and treatment of common health conditions as well as over utilization of the OVHD emergency department. During fiscal year 2015, 45% of OVHD emergency visits were for conditions easily treatable in one of the four rural health clinics.

The four OVHD rural health clinics are the major access point for primary care within the community. They serve as the largest primary care provider for patients covered by the Medi-Cal program. Redesign of ambulatory care at these clinics is the best approach to expanding access within the service area. The projects selected for PRIME participation address these needs in at least three important ways: 1) redesign will increase access at each clinic through operating efficiency gains; 2) better screening and early diagnosis coupled with evidence based treatment will produce patient wellness and collectively improve population health; and 3) an increased focus on abnormal test results and persistent medication use associated with chronic illnesses will help stabilize high utilization patients and free up clinic capacity for access by others.

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 publically elected OVHD Board of Directors are members of the population served by the hospital and its clinics. The Directors are all deeply rooted within the community and understand local needs firsthand. This fact creates a strong commitment to build the infrastructure necessary to support and advance PRIME.

Expanding access to primary care is a central element of OVHD's current strategic objectives. Evidence from hospital community needs assessments and on-going operations demonstrate the need for more accessible, efficient and effective primary care services. To address these needs, in 2015 OVHD recruited a nurse manager to oversee all four rural health clinics. This role was established to strengthen infrastructure, provide a resource to better address standardization and coordination, and "set the stage" for implementation of PRIME.

Recognizing the need for enhancements to data and evidence based decision making, OVHD recently retained a PRIME Project manager with extensive expertise with information technology and project management. The organization has also established a working group charged with planning and implementation of

PRIME projects. The working group includes specialists from nursing, medical staff, finance, information services and administration. Ad hoc groups will be established to incorporate patient input and other community groups on a go-forward basis. All of these components will work collaboratively in developing workflows, processes and ultimately transformation of the OVHD health care delivery system.

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.

Historic patient engagement efforts at OVHD have been limited to satisfaction surveys. PRIME affords an opportunity to expand upon these engagement efforts.

First, OVHD will develop a PRIME Committee that is comprised of providers, staff and patients. This Committee will work with clinic providers and staff to develop workflows and care plans that directly relate to PRIME. The committee will conduct targeted surveys of patients to collect data on their clinic and/or hospital service experience. Ad hoc focus groups may also be utilized to capture input on specific issues. Data collected will be aggregated, with reports provided to the PRIME workgroup.

Secondly, the PRIME workgroup will also provide a written report to the Board of Directors each month on progress toward meeting project goals. Information presented to the Board will occur in open session and the public comment period may be used for community members to submit additional input. The Board may, as needed, hold special meetings to consider or address issues specific to the PRIME Project.

Given that Oak Valley serves a smaller, rural community, these approaches are highly effective for engagement of the patient population served.

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.

OVHD strives to meet the needs of its diverse community. OVHD employs providers and staff who reflect the patient population, and work to ensure patients receive health information and materials in the language of their choice. OVHD also provides interpreter services for multiple languages, including for the hearing impaired and have hospital materials available in the primary language of the patients.

Cultural competency training, including sexual identity and gender orientation, is an essential part of assuring that OVHD is inclusive in serving the community. When health disparities are identified specific to any unique group, such issues will be addressed within the workflow and process change effort. The introduction of care coordinators will also play a role in assuring cultural competency. These staff may be selected, in part, based on the ability to specifically address needs of distinctly identifiable populations.

OVHD intends to continue making these efforts as part of an inclusive, population focused effort to deliver competent service and care.

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.

OVHD has participated in a number of quality improvement projects, such as efforts to rapidly treat sepsis to reduce mortality and the reduction of C-Sections before 38 weeks. These experiences, along with the hospital's adoption of change management and transformation strategies, have given OVHD the experience to sustain PRIME beyond the waiver period. OVHD will sustain PRIME work by undertaking the following:

- Ensuring that patients, providers and staff are involved in the planning, implementation, and continuous review of PRIME.
- Adopting evidence-based tools and incorporating them into our eHR.
- Developing and utilizing data-driven reports to monitor progress and direct rapid cycle improvement efforts.
- Providing education and training, to address identified gaps in knowledge and skills.

OVHD will engage in PRIME learning collaboratives. The organization is committed to long-term system transformation and will use experiences gained through

participation in PRIME to advance changes necessary to improve the effectiveness of health service delivery.

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)

Oak Valley Hospital District (DMPH) Project 1.2 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.

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**:* OVHD recognizes that PCMH will improve efficiency and effectiveness of primary care by leveraging skills of non-physicians and sharing responsibilities among a care team. Additionally, as described in Sections 2.1 and 3.2, access to care was identified as the number one concern of local residents. Limited primary care access

has led to longer primary care appointment wait times, less timely diagnosis and treatment of common health conditions as well as over utilization of the OVHD emergency department.

Planned Design and Implementation Approach*:* Patients, providers and care teams will be involved in program review so they can collaborate to address the processes and components that will be used in the design of PRIME projects.

- Population Management: OVHD will move towards more efficient and effective management of patient populations by augmenting the existing eHR with new technology that will support better appointing processes, facilitate communication with patients regarding upcoming appointments or the need for preventative care screening. These approaches will also improve patient access through staff time management advances. OVHD expects to begin this task in DY12 and complete the task in DY 12.

- Care Coordination: OVHD will identify and train care coordinators in each clinic. Management will ensure trained staff are available to provide patients with timely referrals to specialty care such as for depression or alcohol abuse. Educational material and care plans will be available to help engage the patients with their care. These tasks will begin by conducting a needs assessment in DY 12, and implementing a staff training program in DY12.

- *REAL Data:* OVHD will implement modified workflows to capture more detailed REAL information. Data will be employed to stratify results, identify areas of disparity among patients and to implement process improvement that will result in improved health outcomes. Efforts are expected to begin in DY11 with tasks completed in DY 12.

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

Target Population*:* OVHD expects the target population to be varied due to the range of interventions required for this project as well as the clinical prevention/screening recommendations but overall it will be focused on the Medi-Cal population. For example, for PHQ-2 and SBIRT screenings, we expect the target population to include all our adult Medi-Cal patients, and pediatric Medi-Cal patients. OVHD will begin transformation to the PCMH model at one clinic location and continue to transform other clinics until all clinics in the system are operating in a PCMH model of care delivery.

Vision for Care Delivery*:* PRIME will enable OVHD to not only transform the clinic settings to the PCMH model but to pursue PCMH Recognition from the National Committee for Quality Assurance (NCQA). This achievement 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 emergency department, and will improve health outcomes. Patients will be better managed, improving population health within the community. These objectives, as well as others identified below, will allow OVHD to provide coordinated, efficient and effective care for clinic patients that will extend beyond the PRIME project period.

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. • 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): • Manage panel size, assignments, and continuity to internal targets. • Develop interventions for targeted patients by condition, risk, and self-management status. • Perform preventive care services including mental health and substance misuse screenings and brief interventions (e.g., PHQ-9, SBIRT).
Applicable	**1.2.6** Enable prompt access to care by: • Implementing open or advanced access scheduling.

Check, if applicable	Description of Core Components
	• Creating alternatives to face-to-face provider/patient visits. Assigning frontline workers to assist with care navigation and non-clinical elements of the care plan.
Applicable	**1.2.7** Coordinate care across settings: • 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): 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 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.
Not Applicable	**1.2.9** Improve staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on 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.
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: • 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. • Developing capacity to track and report REAL/SO/GI data, and data field completeness. • Implementing and/or refining processes for ongoing validation of REAL/SO/GI data.

Check, if applicable	Description of Core Components
	• Developing capacity to stratify performance metrics by REAL/SO/GI data and use stratified performance data to identify disparities for targeted interventions. • Developing capacity to plan and implement disparity reduction interventions with input from patients and community stakeholders. • 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.

☒ 1.4 – Patient Safety in the Ambulatory Setting

Oak Valley Hospital District (DMPH) Project 1.4 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.

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: OVHD selected this project because the bulk of work that has been done at OVHD to improve patient safety has focused on the inpatient setting. However, the majority of healthcare that takes place at OVHD occurs in the ambulatory care setting. This current reality increases the chance for errors including delaying treatment, missed diagnoses, medication errors and poor communication. Having recognized there is no consistent process at OVHD for timely communication of abnormal test results to outpatients, or ensuring that appropriate follow-up has been scheduled, changes must be implemented. Improvements to managing abnormal test results will increase patient safety and improve patient outcomes.

Planned Design and Implementation Approach:

- *Enhance eHR Documentation:* OVHD will work with the eHR vendor to ensure the capture of data elements required to a) facilitate easy correlation of persistent medications prescribed to the patient and lab results pertinent to those medications; and b) ensure that abnormal results are flagged and easily identified. Work is expected to begin and be completed in DY 12.

- *Process and Workflow Changes:* OVHD will refine workflows to use the additional data element to facilitate timely and accurate communication of abnormal results to the PCP. Existing scheduling processes will be refined to ensure patients are scheduled with their PCP in a timely fashion in order for the patient and PCP to review the results and plan the patient's care accordingly. OVHD expects to begin work in DY 11 and be completed in DY 12.

- *Performance Improvement:* Data will be collected, aggregated and shared with care teams to monitor progress and facilitate performance improvement efforts. OVHD expects to begin work in DY 11 and it will be ongoing.

- *Performance Dashboards:* Develop data reporting capacities and implement a performance dashboard to track provider-specific performance in these areas starting in DY 11.

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

Target Populations: There are two target populations for this project. The first target population is Medi-Cal patients who are taking persistent medications such as ACE inhibitors or ARBs, Digoxin, and diuretics, and accessing care in one of OVHD's outpatient clinics. The second target population is Medi-Cal patients for whom abnormal test results have been identified, most notably results related to laboratory values that can be affected by persistent medications as well as cancer screening values. For example, patients on diuretics can have their Potassium levels negatively affected, INR values for those on Warfarin must be monitored regularly so medication can be appropriately adjusted, and women between the ages of 50-74 should have appropriate follow-up for an abnormal mammogram (i.e. BI-RAD score of 4 or greater).

Vision for Care Delivery: OVHD visualizes a more structured approach to managing clinic patient use of persistent medications and a comprehensive process for assuring timely follow-up of abnormal test results. Changes to clinic processes and workflows will enable improved disease management via new approaches to medication therapy, close potential gaps in quality related to diagnostic testing, and enable better engagement with clinic patients. These changes to clinic practice combine to enhance the patient experience, improve patient outcomes and reduce the cost of care.

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

Check, if applicable	Description of Core Components
Applicable	**1.4.1** Perform a baseline studies to examine the current workflows for abnormal results follow-up and monitoring of individuals on persistent medications.
Applicable	**1.4.2** Implement a data-driven system for rapid cycle improvement and performance feedback based on the baseline study that effectively addresses all identified gaps in care and which targets clinically significant improvement in care. The improvement and performance feedback system should include patients, front line staff from testing disciplines (such as, but not limited to, radiology and laboratory medicine) and ordering disciplines (such as primary care) and senior leadership.
Applicable	**1.4.3** Develop a standardized workflow so that: • Documentation in the medical record that the targeted test results were reviewed by the ordering clinician. • Use the American College of Radiology's Actionable Findings Workgroup[1] for guidance on mammography results notification. • Evidence that every abnormal result had appropriate and timely follow-up. Documentation that all related treatment and other appropriate services were provided in a timely fashion as well as clinical outcomes documented.
Applicable	**1.4.4** In support of the standard protocols referenced in #2: • Create and disseminate guidelines for critical abnormal result levels. • Creation of protocol for provider notification, then patient notification. • Script notification to assure patient returns for follow up. Create follow-up protocols for difficult to reach patients.
Applicable	**1.4.5** Implement technology-enabled data systems to support the improvement and performance feedback system as well as engage patients and support care teams with patient identification, pre-visit planning, point of care delivery, and population/panel management activities.

[1] *Actionable Findings and the Role of IT Support: Report of the ACR Actionable Reporting Work Group. Larson, Paul A. et al. Journal of the American College of Radiology, Volume 11, Issue 6, 552 – 558. http://www.jacr.org/article/S1546-1440(13)00840-5/fulltext#sec4.3, Accessed 11/16/15.*

Please complete the summary chart:

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

Section 5: Project Metrics and Reporting Requirements

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

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

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

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

Section 6: Data Integrity

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

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

Section 7: Learning Collaborative Participation

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

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

Section 8: Program Incentive Payment Amount

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

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

- DY 11 $ 3,560,000
- DY 12 $ 3,560,000
- DY 13 $ 3,560,000
- DY 14 $ 3,204,000
- DY 15 $ 2,723,400

Total 5-year prime plan incentive amount: $ 16,607,400

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 Measure

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
1.	Perform a gap analysis to identify areas of focus/need	• Research and select for use for this project evidence-based models or nationally recognized guidelines for program/intervention • Perform internal assessment of clinic operations to compare current processes with best-practice PCMH processes • Create a transition team who will champion process (physician, practice manager, clinical and non-clinical staff) • Hire any necessary staff to help with PCMH transition • Build out current district-wide quality management reports to include PRIME project measures • Conduct patient surveys to gather data on actual/perceived barriers to care	1.2	(Jan 1, - June 30, 2016)
2.	Develop a plan to transform clinics into the PCMH model	• Develop a plan outlining the transformational changes to be made based on the gap analysis, patient feedback and quality data needs • Develop education and training materials that supports the transformational changes	1.2	(July 1 – Dec 31, 2016)

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		to be implemented in the clinics • Educate and train the team about the PCMH model (e.g., team-based care, integrated/coordinated care, population health management, patient access) • Develop workflow for new program/intervention • Develop policies and procedures for new program/intervention • Pilot the plan in one clinic setting • Modify the plan as necessary based on staff and patient feedback generated from the pilot clinic • Present outcomes to senior leadership on PCMH transformation and get approval to implement plan clinic wide • Implement the final plan in all clinic settings • Implement rapid-cycle improvement process to resolve any process or quality issues found		
3.	Acquire population health management software	• Work with present EHR vendor to determine if they have a population health module • Convene a workgroup to review and evaluate available population health software, if required	1.2, 1.4	(Jan 1, 2016 – March 31, 2017)

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Establish a team to build and test the software • Resolve any known issues with the software build • Pilot the software in one clinic setting • Resolve any process or quality issues found • Implement the software in all clinic settings		
4.	Hire Staff	• Conduct a workforce gap analysis to determine staff that need to hired, redeployed, retrained to implement new program/intervention • Develop job descriptions • Develop training curricula on duties and responsibilities of role • Recruit for staff to fill the position(s) including care coordinator • Interview and hire staff member(s) • Implement staff training • Implement use of Care Coordinators in a pilot clinic setting • Implement rapid-cycle improvement process to resolve any process or quality issues found • Implement use of Care Coordinators in all clinic settings	1.2, 1.4	(Jan 1, - Dec 31, 2016)
5.	Enhance granularity of REAL data	• Convene a workgroup and educate group on need for more granular REAL data to support PRIME project • Direct workgroup to determine REAL data	1.2	(Jan 1, - June 30, 2016)

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		values to be gathered that will support service area and targeted populations • Develop scripted process/templates to facilitate gathering of data • Work with OVHD IT team and vendor resources to build/modify EHR software to capture REAL data • Pilot the scripted process in one clinic setting • Modify the scripted process based on feedback from staff and patients at the pilot clinic • Implement the final scripted process in all clinic settings		
6.	Development of a process to report and communicate abnormal tests results in the clinic setting	• Convene a workgroup of those involved in process of reporting abnormal test results (e.g., physician, nurses, medical assistants, lab technicians) • Identify gaps in the process • Create workflows to accommodate the new process • Develop policies and procedures for the workflow • Work with OVHD and vendor resources to integrate the process into the EHR • Develop education and training material to support new/changed policies and workflows	1.4	(Jan 1, - June 30, 2016)

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Schedule and conduct staff training • Pilot the process in one clinic setting • Continue regular meetings of the workgroup to monitor change progress • Implement rapid-cycle improvement process to resolve any process or quality issues found		
7.	Development of a process a) to monitor patients on persistent medications, and b) to monitor and track patients on warfarin	• Convene a population health management team to provide input into process development (mid-level providers, Medical Director, Clinic Director, other support staff) • Set improvement goals specific to areas identified by the team (for example, improve percentage of patients who have their HgA1C values checked every three months) • Develop policies and procedures to support new processes and improvement goals • Work with OVHD and vendor resources to integrate the process into the EHR • Develop and implement training material to support new policies and procedures and improvement goals • Schedule and conduct staff training	1.4	(July 1 – Dec 31, 2016)

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Utilize population health management software to identify/track patient visits and lab results associated with chronic conditions that require persistent medications • Continue regular meetings of the population health management team to monitor change progress • Implement rapid-cycle improvement process to resolve any process or quality issues found		

Appendix A-Table 1: Service Population Age Cohort Distribution (US Census Bureau 2010)

Age	Oakdale	State	USA
< 25	36.8% 7,603 people	35.5% 13,217,991 people	34.0% 104,853,555 people
25 - 44	30.1% 6,218 people	31.8% 11,848,422 people	30.3% 93,634,060 people
45 - 64	24.6% 5,083 people	24.9% 9,288,864 people	26.4% 81,489,445 people
> 64	12.3% 2,553 people	11.4% 4,246,514 people	13.0% 40,267,984 people