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

# Plan Modification Guidelines

This document contains guidance from the Centers for Medicare and Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) on formatting guidelines related to submitting PRIME Plan Modifications as outlined in the Special Terms and Conditions (STC), Attachment II – PRIME Program Funding and Mechanics Protocol: Plan Modification Process and Metric Modification Process, Section VI, Part B and C (pages 6 - 8).

## PLAN MODIFICATION GUIDELINES

- **Purpose:** the intention of this document is to allow PRIME entities to modify their 5-Year PRIME plans by adding or removing projects taking into account evidence and learning from their own experience and from the field, as well as for unforeseen circumstances
- **Timing:** submissions will be accepted no more than once a year, and by June 30th of each PRIME DY
  - Other progress updates not requiring a Plan Modification should be submitted via the Mid-Year or Final narrative reports
- When requesting a plan modification please resubmit the entire approved PRIME 5-year plan and make all changes using Track Changes
- On a separate page, after the title page of the 5-year plan, include an introductory section that outlines the modifications, including:
  - The date the plan modification is being submitted to the State
  - The Domain and Project Name in which modifications are being proposed
  - By Domain and by Project (if more than one), list all modifications and include:
    - Whether the proposed modification is *technical* or *substantive*
      - **Technical:** modifications that reflect a clarification or error correction, often occurring in the narrative, but may include changes to projects or metrics (*e.g.*, a terminology change or re-classification)
      - **Substantive:** modifications to metrics that reflect a change in what will be achieved, resulting from newly discovered factors, new evidence, required practices, or PRIME Entity situations that had been unanticipated and are not subject to change
    - Location of proposed modification:
      - If narrative change: state the change is in the narrative
      - Reference the page number where Track Changes are found
    - Summary of proposed modification
    - A justification for the proposed modification

The following is a sample extract from a plan modification (note: the sample does not indicate whether the modifications would be approved by DHCS):

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

Lonetown Hospital

Lonetown Hospital is proposing the following plan modifications to begin in DY 13 starting on July 1, 2017:

1. **Domain 1 Project 1.6: *Cancer Screening and Follow-Up*:**

[Technical]: Project Selection: Update target population for Project 1.6 Cancer Screening and Follow-Up [*See* Page 6]

- *Justification:* Recent data findings produced from the Lonetown Hospital Cancer Committee show there has been an unprecedented spike in HPV cases in the community and a decrease in the HPV vaccination. We would like to launch a targeted approach to women seen at all preventive and annual OB appointments. Additionally, we plan to partner with health educators in the community to share HPV prevention information with adolescents and adults.

2. **Domain 2 Project 2.5: *Transition to Integrated Care: Post Incarceration*:**

[Substantive]: Project Selection: Remove Project 2.5: *Transition to Integrated Care: Post Incarceration from* PRIME 5-year plan [*See* Pages 9 - 12]

- *Justification:* After our PRIME 5-year plan was approved by DHCS, Lonetown Hospital began their data mining in preparation for baseline collection on project 2.5 metrics. The data mining process revealed that we will not meet the minimum metric denominator threshold of 30 PRIME individuals or cases for reporting. Thus, we would like to remove this project from our 5-year plan. Since we have more than the required number of projects (1 project for DMPHs) to participate in the PRIME program, we would like to eliminate this project without adding a project to replace it.

***[PLEASE INCLUDE ENTIRE PLAN – FOR SAMPLE PURPOSES, THIS IS JUST AN EXTRACT]***

## ☒ 1.6 – Cancer Screening and Follow-up

*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]*

The Lonetown Hospital Cancer Committee has identified the cancer-health disparities and gaps in cancer-related resources within the Lonetown community. In 2005, cancer surpassed heart disease as the leading cause of death among county residents. Over 40% residents older than 50 have never had a colonoscopy. Nearly 70% of men over 40 have had no recent prostate cancer screening. We selected this project based on the high prevalence and lack of cancer screening rates.

**Our planned design and implementation approach includes:**

*Development of Cancer Task forces:* Establish task forces to develop screening and follow-up protocols for each indication of breast, cervical, colon and lung cancer consisting of physicians, cancer committee members and community healthcare providers. Utilize national standards, guidelines and best practices to create clinical processes to be implemented across the system. All relevant Lonetown Hospital providers will be trained on the clinical workflows and standards. Via physician coordinated electronic outreach education services, deliver instruction on cancer prevention and early detection to the community (DY11).

*HPV Vaccination:* The task force will promote HPV vaccinations by furthering Lonetown Hospital's participation in community events (e.g. education at high schools, parents and community clinics); Time between biopsy and screening results will be reduced to fewer than 14 business days for all cancers by developing, implementing and training on clinical protocols on BIRADS to Biopsy. Additional screening opportunities will be to developed, such as a low-cost lung cancer screening on a limited basis (DY12).

*Screenings and Community Education:* Skin cancer screenings/cancer prevention opportunities including Women's Health & Men's Health Forums, "Healthy" Lifestyle programs at the Lonetown Hospital Wellness Center and various community health fairs will be held.

*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 will consist of the PRIME eligible Medi-Cal patients at risk for cancer, and have barriers to care. Lonetown Hospital's Medi-Cal population remains much higher with an average of 12%, as compared to 6.3%. We will launch a targeted approach to women seen at all preventive and annual OB appointments to ensure cervical cancer screens are being conducted within the national guidelines. Additionally, we will provide educational materials on HPV and cervical cancer prevention. We will invite Medi-Cal individuals to participate in cancer screenings as described in Metrics Manual 1.6. Work groups for breast, cervical, and colon, will utilize the patient registries developed in the infrastructure, to identify these patients and potentially avoid undetected/untreated cancers.

*Vision for Care Delivery:* Through coordinated outreach and education services, we will deliver targeted education on cancer prevention education and screenings to the community. Expanding cancer education through partnerships with FQHCs will enable Lonetown Hospital to focus on our target population, specific sites and cancer related diagnoses. Developing cancer screening and treatment protocols will ensure that Lonetown providers are using best practices. By educating students and guardians about the HPV risks, availability of testing, and vaccination, we will manifest a reduction in HPV-related cervical cancer. As barriers to breast cancer screening are eliminated, time between suspicious mammogram to biopsy, to surgery, will be reduced. By partnering with our community physicians for colorectal cancer screenings and treatment, diagnoses and interventions such as surgery, chemotherapy, and nutritional intake monitoring can occur earlier.

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

☒ **1.6.1** Develop a multi-disciplinary cross-participating PRIME entity task force to identify principle-based expected practices for screening and follow-up for the targeted services including, but not limited to:

- Standard approach to screening and follow-up within each DPH/DMPH.
- Screening:
  - Enterprise-wide standard approach to screening (e.g., ages, frequency, diagnostic tool).
- Follow-up for abnormal screening exams:
  - Clinical risk-stratified screening process (e.g., family history, red flags).
  - Timeliness (specific time benchmark for time from abnormal screening exam to diagnostic exam).

☐ **1.6.2** Demonstrate patient engagement in the design and implementation of programs.

☐ **1.6.3** Collect or use preexisting baseline data on receipt and use of targeted preventive services, including any associated disparities related to race, ethnicity or language need.

☒ **1.6.4** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to USPSTF A and B Recommendations.

☒ **1.6.5** Improve access to quality care and decrease disparities in the delivery of preventive services.

☒ **1.6.6** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.

☒ **1.6.7** Adopt and use certified electronic health record systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population management approaches (e.g., in-reach, outreach) to reduce gaps in receipt of care.

☒ **1.6.8** Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.

☐ **1.6.9** Implement a system for continual performance management and rapid cycle improvement that includes feedback from patients, community partners, front line staff, and senior leadership.

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

| | For DPHs | For DMPHs |
|---|---|---|
| **Domain 1 Subtotal # of DPH-Required Projects:** | **3** | **0** |
| **Domain 1 Subtotal # of Optional Projects**<br>**(Select At Least 1):** | **N/A** | **1** |
| **Domain 1 Total # of Projects:** | **N/A** | **1** |

## ☒ 2.5 – Transition to Integrated Care: Post Incarceration

*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]*

The Lonetown Detention Facility lies within close proximity of the Lonetown Hospital which is the medical facility for inmates with specialty care needs making for a natural partnership.

**Lonetown's planned design and implementation approach includes:**

*Infrastructure development:* Identify the optimal location, times of service and hard asset resources needed located within the healthcare district (DY 11-12).

*Resource development:* Recruit providers to support the needs of the patients of the clinic. Identify post incarcerated individual(s) who can act as the liaison between the releasing facility and the clinic.

*Program development:* Create resources accessible to patients of the clinic that include – referrals to local specialists for treatment chronic conditions, behavioral health and substance abuse services, social services and access to prescription medications and teaching (DY12).

*Care Transition Clinic:* By developing a post incarceration care transition clinic, associated training for clinical staff to manage the unique needs of the specific population and assigning the patients to a healthcare clinical liaison, the service needs can be met to reduce unnecessary healthcare costs (DY12).

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

*Target Population:* We have identified specific target populations for this project. Current inmates with anticipated release dates who will be eligible for Medi-Cal upon release and who have a chronic health condition: cancer, diabetes, heart disease, COPD, asthma and substance abuse.

*Vision for Care Delivery:* PRIME will enable Lonetown to execute a scalable strategy in which patient-centered care is the focal point. The initial identification of the patient target population will take place in collaboration with the Lonetown Police Department. Lonetown Hospital will execute a strategy to link these patients with the appropriate clinical setting where medical and social resources can be provided in a timely manner post release.

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

☒ ~~**2.5.1 Develop a care transitions program for those individuals who have been individuals sentenced to prison and/or jail that are soon-to-be released/or released in the prior 6 months who have at least one chronic health condition and/or over the age of 50.**~~

☒ ~~**2.5.2** Develop processes for seamless transfer of patient care upon release from correctional facilities, including:~~

- ~~Identification of high-risk individuals (e.g., medical, behavioral health, recidivism risk) prior to time of release.~~
- ~~Ongoing coordination between health care and correctional entities (e.g., parole/probation departments).~~
- ~~Linkage to primary care medical home at time of release.~~
- ~~Ensuring primary care medical home has adequate notification to schedule initial post-release intake appointment and has appropriate medical records prior to that appointment, including key elements for effective transition of care.~~
- ~~Establishing processes for follow-up and outreach to individuals who do not successfully establish primary care following release.~~
- ~~Establishing a clear point of contact within the health system for prison discharges.~~

☒ ~~**2.5.3** Develop a system to increase rates of enrollment into coverage and assign patients to a health home, preferably prior to first medical home appointment.~~

☒ ~~**2.5.4** Health System ensures completion of a patient medical and behavioral health needs assessment by the second primary care visit, using a standardized questionnaire including assessment of social service needs. Educational materials will be utilized that are consistent with the cultural and linguistic needs of the population.~~

☒ ~~**2.5.5** Identify specific patient risk factors which contribute to high medical utilization~~

- ~~Develop risk factor-specific interventions to reduce avoidable acute care utilization.~~

☒ ~~**2.5.6** Provide coordinated care that addresses co-occurring mental health, substance use and chronic physical disorders, including management of chronic pain.~~

☒ ~~**2.5.7** Identify a team member with a history of incarceration (e.g., community health worker) to support system navigation and provide linkages to needed~~

~~services if the services are not available within the primary care home (e.g., social services and housing) and are necessary to meet patient needs in the community.~~

- ☐ ~~**2.5.8** Evidence-based practice guidelines will be implemented to address risk factor reduction (e.g., immunization, smoking cessation, screening for HCV, trauma, safety, and overdose risk, behavioral health screening and treatment, individual and group peer support) as well as to ensure appropriate management of chronic diseases (e.g., asthma, cardiovascular disease, COPD, diabetes).~~

- ☒ ~~**2.5.9** Develop processes to ensure access to needed medications, DME or other therapeutic services (dialysis, chemotherapy) immediately post-incarceration to prevent interruption of care and subsequent avoidable use of acute services to meet those needs.~~

- ☐ ~~**2.5.10** Engage health plan partners to pro-actively coordinate long-term care services prior to release for timely placement according to need.~~

- ☒ ~~**2.5.11** Establish or enhance existing data analytics systems using health, justice and relevant community data (e.g., health plan data), to enable identification of high-risk incarcerated individuals for targeted interventions, including ability to stratify impact by race, ethnicity and language.~~

- ☐ ~~**2.5.12** Implement technology-enabled data systems to support pre-visit planning, point-of-care delivery, population/panel management activities, care coordination, and patient engagement, and to drive operational and strategic decisions including continuous QI activities.~~

- ☐ ~~**2.5.13** 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.~~

- ☒ ~~2.5.14 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 care model.~~
  - ~~Involving staff in the design and implementation of this project.~~

- ☐ ~~**2.5.15** Engage patients and families using care plans, and self-management education, including individual and group peer support, and through involvement in the design and implementation of this project.~~

- ☒ ~~**2.5.16** Participate in the testing of novel metrics for this population.~~

***Please complete the summary table below:***

| | For DPHs | For DMPHs |
|---|---|---|
| **Domain 2 Subtotal # Of DPH-Required Projects:** | **3** | **0** |
| **Domain 2 Subtotal # Of Optional Projects (Select At Least 1):** | **N/A** | **01** |
| **Domain 2 Total # Of Projects:** | **N/A** | **01** |