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

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

Table of Contents

General Instructions

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

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

Scoring

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

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

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

Section 1: PRIME Participating Entity Information

Health Care System/ Hospital Name: Bear Valley Community Healthcare 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.

Bear Valley Community Healthcare District (BVCHD) is located in Big Bear Lake California. Big Bear is a small isolated mountain community located in the San Bernardino mountains (elevation approximately 7000 feet) with a population of approximately twenty thousand full-time residents. Big Bear is known as a resort town for its seasonal recreation activities. Approximately 70% of all homes located in Big Bear Lake are vacation homes that are unoccupied during a large part of the year. According to kidsdata.org, approximately 72% of children enrolled in the Bear Valley Unified School District are currently receiving free and reduced lunch, (the State of California's rate is 59.2%) which serves as an indicator of poverty.

Currently BVCHD serves as the areas only hospital, offering services including but not limited to; Emergency Room, Rural Health Clinic, Physical Therapy, Skilled Nursing Facility, and Family Resource Center.

Physical Health: According to the 2015 San Bernadino Community Indicators Report, 72% of adults in our county are currently overweight or obese. 12.3% of our residents have been diagnosed as diabetic and 29.2% are currently struggling with high blood pressure.

Behavioral Health: According to the 2015 San Bernardino Community Indicators Report, 46,211 residents in our county are currently receiving County Mental Health Services. According to the National Institute of Mental Health, an estimated 13 million American's (approximately 1 in 17) have a seriously debilitating mental illness. In 2013-2014 it was estimated that over 65,500 residents in San Bernardino County needed mental health

services to aid them in the struggle against a serious mental illness.

In 2015, The Office of Disease Prevention and Healthy Promotion released *Healthy People 2020*, where they identified the major links between mental health and physical health. Mental illnesses, such as depression and anxiety, were noted to reduce one's ability to participate in health-promoting behaviors such as eating right, exercising, and minimizing use of alcohol and tobacco. As a result problems with physical health can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

According to our most recent data, BVCHD is seeing approximately 10% of our patients, either in the emergency room, or in the clinic who are being treated for a mental health condition, or a drug and alcohol related issue.

Health Disparities: San Bernardino County continues to see disparities in healthcare, and BVCHD is no exception to these disparities. Due to the rural location of BVCHD there are very limited resources available to the local residents. In 2015 BVCHD's pain management Doctor resigned due to the extensive commute, often in inclement weather. This forced many of our patients to seek treatment elsewhere, including our Emergency Room. The community of Big Bear has one mental health community based organization with very limited resources. In 2014 BVCHD entered into a contract with a telehealth MFT that allowed us to provide warm hand-off referrals to help aid in the disparities that exist in our community surrounding mental and behavioral health. Through this partnership we have seen an increase in use of services, but now the challenge has been keeping up with the rising demand, and treating those in crisis. There are currently no behavioral health crisis services available in Big Bear, so patients experiencing such symptoms are often escorted to a facility over an hour and half away from their home by local law enforcement. Through PRIME we would like to explore options into management of the chronic non-malignant pain management patients, hoping to alleviate many of the scenarios that lead up to hospitalization.

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.

BVCHD serves the incorporated city of Big Bear Lake, as well as the unincorporated areas of Big Bear City and its outlying areas. We specialize in rural health and have been collaborative in nature since our inception. BVCHD lacks many resources, yet we have managed to service our community continually for over 40 years. In 2015 BVCHD entered into an affiliation with Loma Linda, allowing our patients increased access to services and specialized care, however Loma Linda remains an hour and half drive from our town and for many of our patients, due to health and income restrictions the drive is not possible.

Income: According to the U.S. Census, the average per capita income in San Bernardino County is $52,323.00 and the average median family income in Big Bear is $32,869.00. Average residents in the Big Bear valley are living off of approximately 62% less then the average Californian. Over 400,000 households in San Bernardino County are currently receiving CalFresh assistance, serving as an indicator for poverty.

Race/Ethnicity and Language: Big Bear's population is 67.8% White, 23.6% Hispanic, 2.9% Native Hawaiian and other Pacific Islander alone, 1.7% Black alone, 0.8% American Indian alone, and 0.7% two or more races. The primary language spoken is English, however with 23.6% of the population self-identifying as Hispanic, there is a large number of Spanish speakers that reside in the Big Bear Community.

Age: The population of Big Bear is older than the state and national average. Big Bear's median age is 44.7, California's is 36.7 and the national median age is 38.5. According to the US Census, the age break down for Big Bear is as follows:

- 0-18 years 29.3%
- 19-64 years 56.2%
- 65 and over 14.5%

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.

In 1970 the non-profit Government Hospital District was formed in a general election by a 95% favorable vote. In 1974 Bear Valley Community Healthcare District opened its doors to serve as the areas only hospital and emergency room in the Big Bear Valley. BVCHD is a full service general acute care district hospital.

In 2015 BVCHD became a *Critical Access Hospital,* serving permanent residents as well as visitors to our resort community. BVCHD has a 9 bed acute unit, a 21 bed Skilled Nursing Facility, a 24-hour Emergency Care Room, a Physical Therapy Department, a 12-room Rural Health Clinic, and a Family Resource Center.

In fiscal year 2015, BVCHD's payer mix was: 19% Medicare, 38% MediCal 10% Blue Cross, 27% Commercial, 1% Work Comp, and 5% Private. In fiscal year 2015, BVCHD saw 10,593 Emergency Room visits, and 18, 551 rural health clinic visits.

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.

In 2014 BVCHD converted to an Electronic Medical Records (EMR) system. A Quality Improvement (QI) team meets monthly to discuss issues surrounding quality using data from the EMR and third party surveys. The QI team's goal is to improve quality of patient care and implement effective systems. QI sub-committees were formed in 2016 focusing on customer service to provide additional direction and recommendations to the Board as they enter into a new 5-year strategic plan.

Data Collection: Our current EMR system is integrated between our hospital and rural health clinic. BVCHD currently has mechanisms in place to help measure outcomes regarding pain management. Through the PRIME project we will use work groups to develop standardized pain care agreements, implement bio/psycho/social evaluations to establish and monitor individualized care plans.

Reporting: BVCHD uses dashboards and work groups to ensure quality improvement and accountability. Under the PRIME project we would enhance this practice by implementing a patient advisory committee to ensure targeted measures for improvement.

Monitoring: BVCHD currently reviews policies and procedures through review teams including an approval process from committees at the management, administrative and physician level. Monthly QI meetings are held where metrics are reviewed to determine successes as well as opportunities for improvement.

The biggest challenge that BVCHD will face in meeting the PRIME reporting requirements is the small size of our organization. We anticipate hiring additional staff to support the PRIME project, including but not limited to a Licensed Clinical Social Worker, Health Navigator and additional analytic staff to help track the success of the PRIME project. Although the size of our staff and operations can be a challenge, it also creates great opportunity because we all operate on the same platform, making tracking and program alterations streamlined from the emergency department to the rural health clinic. This streamlined process will make it easier to monitor progress and provide consistent reporting.

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.*

BVCHD's main goal is to improve the health and quality of life of our patients by ensuring our primary care providers, emergency room providers and support staff's ability to identify, and manage chronic non-malignant pain using a function based, multimodal approach, and to improve outcomes by distinguishing between and implementing appropriate care plans, for patients who will benefit from opioids and patients who are likely to be harmed by them.

BVCHD intends to use PRIME to implement and expanded systems of care to decrease disparities, to create seamless care, and to further integrate systems that support holistic care. BVCHD intends to develop and adhere to policies and procedures that support specific opioid prescription guidelines that incorporate holistic modalities. We are seeking to implement updated strategies through the engagement of patients, and coordinate a chronic pain team through multiple disciplines to alleviate disparities among our chronic non-malignant pain management patients.

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.*

For this project BVCHD will be focusing on (1) Implementation of a cooperative care management program for our chronic non-malignant pain management patients. (2) To develop culturally, linguistically and literacy level appropriate assessments and processes to identify patients and improve overall health.

BVCHD plans to streamline the screening process used to identify our chronic non-malignant pain management patients. We plan to do this by implementing a multi disciplinary team including a LCSW, health navigator, physician champion, medical support staff, physical therapy, pharmacy, and anesthesiology/pain management. We plan to use a standardized approach for screening using the Screening for Clinical Depression, PHQ-9, and the SBIRT in inpatient and outpatient settings.

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;*

BVCHD has selected 2.6 Chronic Non-Malignant Pain Management. This project directly corresponds to the project aims and will enable the healthcare district to develop the infrastructure needed to serve the population indicated. Project implementation would include the development of a comprehensive outpatient pain management program that would include a multidisciplinary, evidence based approach to consistent management of chronic non-malignant pain.

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*

N/A

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.*

After 5 years working with the PRIME project, patients served by BVCHD will receive whole-person care, including a multi-modality approach to care. Patients who suffer from chronic non-malignant pain will be screened and treated appropriately using multi disciplines to establish a care plan though care coordination, traditional, and non-traditional medical care. We will continue to build our infrastructure by strengthening systems that support whole person health. Our behavioral health staff will be able to connect to our medical staff and community based organizations in a seamless effort to support quality of care, and holistic care. We anticipate a reduction of emergency room visits by the chronic non-malignant pain management patients. We anticipate through a holistic approach we will reduce admissions, increase functional ability, and improve quality of life.

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.

Lack of resources as described in section 2.1 identifies the need to focus on Chronic Non-Malignant Pain Management. As the only healthcare provider within a 43-mile radius, we see and understand the need for pain management in our service area. Our pain management doctor was seeing on average 80 patients per month, and when he resigned the emergency room and primary care physicians did their best to absorb this population, however with limited resources, we understand this is not best practice and would like to build capacity to strengthen holistic health among this population in our service area.

There is a great need in our community to service this population, and currently there are very limited resources to aid this process. We are seeking to enhance our ability to screen, identify and refer, to standardize the process to connect patients to the treatment they are needing by offering a whole-person care approach. We believe that if this project is successful it will also decrease the mis-use of drugs and alcohol among this population. By using a whole-person approach we will be better able to identify co occurring mental health and physical health issues, treating behavioral health will impact our ability to improve overall health outcomes for this vulnerable population.

We believe that our patients are better managed in a community care setting, and this process will allow us to develop a better system of care coordination and care delivery. Through multi disciplinary teams we will be able to address the whole person, thereby decreasing some of the disparities this population faces in our community. By improving this process, we will in turn improve patient care and the quality of care they receive, this will in turn result in better outcomes, leading to better health outcomes.

PRIME project implementation will be overseen by the Board of Directors. Quarterly reports will be presented to the Board through the Quality Improvement Committee report. The project leads will be the Chief Nursing Officer in cooperation with an anticipated LCSW new hire. Team members will include but are not limited to the Director of Outpatient Services, Emergency Department Manager, and Controller.

Project monitoring and feedback mechanisms will be instituted in order to ensure data driven decision making. Metrics shall include utilization of the NQF 0418: Preventative Care and Screening: Screening for Clinical Depression and Follow up Plan. A standardized, age appropriate PHQ screening tool for depression for patients age 12 and older shall be used to identify patients having a positive depression screen. Monitoring shall include a documented follow up plan for those identified. Chart audits will be conducted to ensure an executed opioid agreement and annual urine toxicology screen is documented. Metrics will be evaluated quarterly for inclusion in the Quality Improvement report to the Board of Directors. Regularly scheduled meetings will be held with the multi modal pain management team to illicit feedback, review target measures, evaluate program methodology, and provide recommendations for program improvement.

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).

BVCHD is a Community Hospital, meaning that we are governed by an elected board made up of citizens of our community. Our commitment to our community and the patients we serve is vital to our work, and necessary for all operations as we remain

accountable to the community that we serve. Our current Board of Directors is in support of this program and any program that builds capacity and opportunities for our staff as well as our patients.

In 2016, our Quality Improvement team formed several committees to make sure that we were giving the best patient experience possible, that we were meeting the needs of the high risk population and that we were building infrastructure to create a robust system of care for our patients. With the implementation of the PRIME program, we will be adding an additional topic during our QI monthly meetings to discuss this project, as well as analyze its metrics, and ensure that we are implementing a holistic care for our most vulnerable patients.

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.

BVCHD will request that stakeholders and recipients be a part of the planning and implementation process of our PRIME project. We plan to accomplish this through research based techniques and practices such as consumer participation, advisory boards, and continued quality improvement committees. BVCHD is in the process of establishing a new 5-year strategic plan, and through this process we have identified a need for a project such as PRIME. We have actively engaged community stakeholders our strategic plan process and based on our rural community, we have been successful in the past with engaging stakeholders and recipients. BVCHD intends to strengthen its ties to the community by building relationships and developing Patient Advisory teams to seek opportunities to engage the community in improving the patient experience and recognizing community priorities.

Further, BVCHD is a member of the Big Bear Valley Community Collaborative, The Mental Health Alliance, and the California Telehealth Network which provide support services and community resources to our patients and at risk population. These relationships will help strengthen our program and increase our ability to engage stakeholders to make informed decisions when it comes to appropriate holistic care.

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.

As the only healthcare provider in the rural town of Big Bear, BVCHD has been very

conscious of our population and who our patients are. We have worked hard to present services in a cultural, language and literacy appropriate fashion. We employee a diverse staff to reflect our commitment to cultural competence and it has been a priority for us to ensure that patients receive access to health information in their preferred language. Educational material can be presented to patients in English or Spanish, and medical translation services are available at all times. BVCHD intends to expand its cultural diversity practices by building outreach services and actively engaging our community by establishing patient advisors to better understand community needs. Services will be enhanced based on community assessment and recognized disparities.

BVCHD supports an annual community health fair that encourages our population to engage in resources available within the community. The health fair provides opportunities for community members to receive assistance in navigating the Affordable Care Act, recognizing resources for financial assistance, and connects the low income population with eye exams and prescription lenses.

Cultural sensitivity is a priority for the healthcare district, annual orientation training addresses cultural diversity and the Human Resources Department is working to increase training opportunities for provider and staff training related to cultural competence and health disparities.

3.6 Sustainability. [No more than 150 words]

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

BVCHD has established a uniform model for process improvement which includes formation of workgroups and the development of a detailed action plan with associated deadlines and responsibilities. As a result of the success of this process improvement model we have been able to sustain long-term changes in many departments throughout the district. BVCHD will utilize this model to sustain PRIME project improvements. The following strategies will be included in the sustainability plan:

Train management staff in the Team-STEPPS program and implement this evidence-based teamwork system to assist us in optimizing PRIME aims, and improving communication and teamwork skills among employees and physicians.

Engage providers and staff in the planning and implementation of the project to increase ownership and buy in for project initiatives. This will include the training and utilization of clinical and non-clinical champions.

Improve continuity of care between providers, staff and patients by developing a

comprehensive pain management program. Adopt evidence-based practices in alignment with the CDC's guidelines for prescribing opioids for chronic pain to ensure patients have access to safer, more effective pain management.

Provide extensive education and training related to the project at the time of implementation and ongoing as new opportunities for improvement and development are recognized.

Ensure Executive level support of the design and execution of the PRIME project initiatives.

Conduct and analyze qualitative and quantitative data in order to encourage data-driven decision making processes and develop measurable outcomes that are sustainable.

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

☒ 2.6 – Chronic Non-Malignant Pain Management

BVCHD selected this project in order to build an infrastructure to support a district wide pain management program that will enable us to improve care for patients experiencing chronic pain. Due to the district experiencing a loss in program coordination due to the resignation of a pain management specialist physician, the pain management program and prescribing practices have been inconsistent and care coordination has been fragmented. Building a multidisciplinary program that includes care management and coordination as well as consistent evident based guidelines for prescribing would allow us to meet the needs of the chronic pain population that is currently underserved in our district. Throughout the implementation of this project we intend to:

Create and continue to build care management and care coordination services that would be provided to our patients. The care management program would include new services in the areas of social work and care navigation. BVCHD will build a mult-disciplinary team to coordinate chronic non malignant pain management services. Team members could include primary care providers, specialists, emergency room physicians, nursing, support staff and recruitment of additional resources to expand opportunities and better meet needs and sustain/ support ongoing community needs related to pain management. Key components of the multi-disciplinary team could include health promoters, navigators and outreach coordinators. This team would initially help to identify needs of this high risk population and then continue to build, implement and sustain programming at the district and community level. The team would integrate emergency and primary care, behavioral health, alternative medical modalities, education and community resources. This team would seek to include and recognize additional patient populations that could benefit from care management. BVCHD will develop a program that would include the hire, training, and retraining of staff to meet the needs of the population served in this program.

Develop policies, procedures and guidelines that reflect evidence based practices to address safe and consistent prescribing, as well as recognition of risk factor reduction. The guidelines that are developed would be utilized to ensure appropriate management of chronic pain and associated secondary diagnosis.

Collect and analyze quantitative and qualitative data to ensure adequate representation of the population and associated needs. Initiate indicator tracking procedures to enable the identification of the target population and institute program inclusion criteria. Project monitoring and feedback mechanisms will be instituted in order to ensure data driven decision making. Metrics shall include utilization of the NQF 0418: Preventative Care and

Screening: Screening for Clinical Depression and Follow up Plan. A standardized, age appropriate PHQ screening tool for depression for patients age 12 and older shall be used to identify patients having a positive depression screen. Monitoring shall include a documented follow up plan for those identified. Chart audits will be conducted to ensure an executed opioid agreement and annual urine toxicology screen is documented. Metrics will be evaluated quarterly for inclusion in the Quality Improvement report to the Board of Directors. Regularly scheduled meetings will be held with the multi modal pain management team to illicit feedback, review target measures, evaluate program methodology, and provide recommendations for program improvement.

Conduct training for safe prescribing, clinical and non clinical staff in the areas of risk assessment, case management, cultural awareness, and early intervention. Training would be designed to include intensive training during critical program implementation periods as well as ongoing to address identified areas of opportunities for education.

Assemble a multidisciplinary care management team that would be assigned to evaluate program effectiveness and make recommendations for further development of the pain management program. This team would review cases, explore additional opportunities for further treatment modalities and outreach programs, and evaluate additional population specific needs and concerns.

Engage population specific patients in the design and implementation of the project through the use of patient advisors. The patient advisors would be selected by the implementation team and utilized to review program design and make recommendations based on patient perception and experience.

This project will enable our system to improve care for the target population by identification, evaluation, and provision of additional services such as but not limited to group counseling, drug and alcohol addiction recovery, transportation services, pain management specialists, and life enhancement services. The program would assist patients in navigating the complex healthcare system and ensure patients are referred to appropriate resources available within the community.

Patient care would be improved by ensuring safe and effective prescribing practices. These practices would improve the function / health related quality of life for patients with chronic pain by decreasing the rate of opioid prescriptions and improving the effect of non-opioid medications and modalities. Implementation of this program would decrease the rate of ED visits and acute hospitalizations related to opioid abuse and overdose for these patients.

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

Check, if applicable	Description of Core Components
Applicable	**2.6.1** Develop an enterprise-wide chronic non-malignant pain management strategy.
Applicable	**2.6.2** Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**2.6.3** Implement or adapt a state or nationally recognized methodology for the assessment and management of chronic pain.
Applicable	**2.6.4** Implement protocols for primary care management of patients with chronic pain including: • A standard standardized Pain Care Agreement. • Standard work and policies to support safe prescribing practices. • Comprehensive pain history including psycho/social evaluation, functional evaluations, care plan, pain medication risk/benefit informed consents, ongoing monitoring of plan/outcomes (e.g., use of standardized monitoring template for follow-up visits for CNP), aberrant behavior screening and management protocols. • Guidelines regarding maximum acceptable dosing.
Applicable	**2.6.5** Provide culturally, linguistically and literacy level-appropriate patient education on the pathology of chronic pain, rationale for rehabilitation and expected goals of treatment.
Applicable	**2.6.6** Coordinate a chronic pain care team that minimally consists of a physician champion and medical support staff. Suggestions for care clinicians from other disciplines include occupational and physical therapy, behavioral health, pharmacy, substance use disorder specialists, neurology, occupational medicine, anesthesiology/pain management, home care, social work, and physical medicine and rehabilitation.
Not Applicable	**2.6.7** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, and team based population/panel management and care coordination.
Not Applicable	**2.6.8** Determine population ICD-9/ICD-10 codes for data collection that is unique to patients with chronic pain on opioids and develop a registry for pain assessments, care agreements, medication refill standing orders and urine toxicology screening.
Not Applicable	**2.6.9** Utilize provider activity report card to provide feedback to providers on how their chronic pain management practice compares to peers and benchmarks.

Check, if applicable	Description of Core Components
Not Applicable	**2.6.10** Establish a policy for monitoring and maintaining opioid agreements for prescription refills with other clinics, pharmacies, dentists and specialists.
Applicable	**2.6.11** Develop a process for scheduling pain focused follow-up patient visits to ensure that patients receive refills in a timely manner while also receiving recommended monitoring for signs of diversion or misuse.
Applicable	2.6.12 Develop staff and clinician training regarding the organization's process for managing patients with chronic non-malignant pain.
Applicable	**2.6.13** Train providers to identify signs of prescription opioid use disorders and provide treatment options for patients diagnosed with opioid use disorders, including suboxone treatment, referral to methadone maintenance, referral to inpatient and outpatient substance use disorder treatment facilities, and referral to needle exchanges.
Applicable	**2.6.14** Develop and implement protocols for prescribing naloxone to patients receiving opioids for chronic pain.
Applicable	**2.6.15** Identify standardized multidimensional pain assessment, functional assessment, psychological assessment, and opioid assessment tools that meet the needs of the care clinicians and are appropriate for the patient populations.
Applicable	**2.6.16** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. Timely, relevant and actionable data is used to support patient.

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):		**1**
Domain 2 Total # Of Projects:		**1**

Section 5: Project Metrics and Reporting Requirements

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

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

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

X 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.

X 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.

X 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 $ 1,500,000
- DY 12 $ 1,500,000
- DY 13 $ 1,500,000
- DY 14 $ 1,350,000
- DY 15 $ 1,147,500

Total 5-year prime plan incentive amount: $ 6,997,500

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

X 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.	Improve assessment/reassessment of patients with chronic pain diagnosis	Evaluate current assessment tools for alcohol and drug misuse, depression, pain level and functionality	2.6	July 2016- June 2017
2.	Improve use of multimodal pain management strategies	Expand current pain management resources to include holistic options	2.6	- July 2016- June 2017
3.	Standardize opioid prescribing practices by implementation of evidence based guidelines	Monitor compliance with prescribing guidelines	2.6	July 2016 June 2017
4.	Decrease ED visits related to opioid overdose	Establish process for pain focused follow-up visits to ensure compliance with pain management agreement including education regarding opioid misuse	2.6	July 2016 June 2017