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

San Mateo County Health System/ San Mateo Medical Center

Health Care System Designation(DPH or DMPH)

DPH

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.

San Mateo Medical Center is located in San Mateo. The health care needs and disparities of our community as identified in our most recent County Community Assessment are summarized below.

Physical Health.

- Obesity: 55.4% of San Mateo County respondents are overweight. This represents a statistically significant increase in overweight prevalence when compared to prior County Assessment results. Additionally, 21.7% of San Mateo County adults are obese with a Body Mass Index equal to or greater than 30 and is a significant increase since 1998.
- Rating of Health & Exhibit Healthy Behaviors: There has been a steady decrease in overall health rating, although the county is objectively healthier. There has been little adoption in getting individuals to maintain healthy behaviors and only 5.4% of respondents report each of 4 basic health behaviors. The past trend of declining mortality rates is ending and is likely to reverse in the next 5-10 years. The report states that "*We have completely failed in getting individuals to maintain healthy behaviors…We need to stop trying to get individual behavior change and move to policies that promote health."*
- Diabetes: Rates of diabetes are up 2.5 times over the past 10 years. 10% of respondents reported having diabetes and this is equivalent to 57,130 people. This percentage is significantly higher than previous levels.
- Cardiovascular Disease: 85.4% of residents exhibit at least one cardiovascular risk factor (smoking, no regular physical activity, high blood pressure, high cholesterol, or being overweight).

Behavioral Health. Behavioral health issues are a challenge for San Mateo County.

- Binge drinking rates for men ages 18-24 are 40%
- Satisfaction with one's life: The number of people reporting difficulty around feeling satisfied with one's life (45.6%) and difficulty in family relationships (34%) both increased since the last assessment.

- Depression: A quarter of respondents experienced prolonged symptoms of depression (2+ years) where they were sad or depressed on most days.

Health Disparities.

- Obesity: The obesity prevalence increases with age and decreases with education and income levels. Obesity is highest among African Americans and Hispanics and is more prevalent in the North San Mateo County region.
- Diabetes: The greatest increase in diabetes has been in Caucasians, Females, and those over the age of 65.
- Depression: Women, lower income, less educated, and Latino respondents had higher rates of prolonged symptoms of depression where over a period of two years or longer they were sad or depressed on most days.

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.

San Mateo Medical Center is located in San Mateo and serves the diverse population of San Mateo County.

Age. There has been a decrease in those aged 20-44 in the county and an increase in those aged 45-65. The age pyramid is flattening and the age breakdown is as follows:

- Under 5 yrs (6.5%)
- 5 to 19 (17.9%)
- 20 to 44 (34.5%)
- 45 to 64 (27.8%)
- 65 to 84 (11.2%)
- 85 + (2.1%)

Race. The White population is expected to decrease considerably (nearly 50% by 2040) while Hispanic and Asian/Pacific Islander populations are expected to increase dramatically. According to the needs assessment, in 2000 the population of San Mateo County was 50.7% White, 21.9% Hispanic, 21.5% Asian/Pacific Islander, 3.4% Black, and 2.5% Other/ Multirace.

Income: Poverty and relative poverty are increasing, especially in children and seniors. A total of 18.9% of adults live below 200% of the Federal Poverty Level. This is a significant increase from the last survey results. Among respondents with a high school education or less, 45.5% report living below the 200% Federal Poverty Level. Black and Hispanic respondents demonstrate higher proportions of poverty.

Real per capita income was $68,582 and the average weekly wages were $1,450 down 13% from the prior survey.

In the San Mateo Medical Center patient population, our REAL data has shown that the preferred language preference is as follows:

- 51% Prefer English
- 45% Prefer Spanish
- 1% Prefer Tagalog
- 1% Prefer Chinese
- 2% Prefer Another Language

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.

San Mateo Medical Center (SMMC) is an essential community healthcare provider to the most vulnerable and underserved in San Mateo County. We serve more than 70,000 children, adults, and older adults every year. 40,000 of these individuals are served in ongoing primary care relationships. In addition to an acute care hospital, medical and psychiatric emergency services, and in-patient psychiatric services in San Mateo, the Medical Center operates eight health centers offering pediatric and adult primary care, specialty services, dental services and mental health services. Our public hospital is fully accredited by the Joint Commission. We are licensed to operate 509 beds including 7 intensive care beds, 64 medical/surgical beds, 32 skilled nursing beds and 34 inpatient psychiatric services beds. The majority of the remaining licensed beds are housed in a long term care facility in Burlingame. We also offer a unique service through the Keller Center for Family Violence Intervention which meets the needs of victims of physical and sexual abuse by providing medical, emotional, social and legal care and support. Our payor mix is 61% Medi-Cal, 17.6% Medicare, 13.7% County Indigent Program (ACE) 2.4% Self Pay, and 5.3% Other. The mission of San Mateo Medical Center is to "partner with patients to provide excellent care with compassion and respect." As part of the San Mateo County Health System, SMMC serves the health care needs of all residents of San Mateo County, with an emphasis on education and prevention.

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.

Reporting requirements for SMMC are supported by a Business Intelligence team of three full time and two contracted report analysts. The report analysts each have over seven years of experience working with SMMC data. Based on the number of metrics required for PRIME reporting, we have assigned two senior report analysts to the project. They work closely with clinical staff to complete mapping PRIME metrics for reporting and determining if there are gaps in data collection that will impact our ability to report. After the initial baseline data is collected for each metric, the Business Intelligence team will also develop a dashboard report to allow each PRIME Project Lead to monitor their monthly progress on their project's metrics.

The San Mateo Business Intelligence team uses standard work to develop report requirements, create reports, perform validation and publish data according to user specifications. The team already produces a number of clinical quality reports (e.g., diabetes care, discharged patients follow up care, immunization study) for SMMC's use. For PRIME data, we will rely on our electronic medical record data systems and their data warehouse communication. Our primary concern for PRIME's reporting requirements is having sufficient time to create the metrics and complete the data validation prior to the first report deadline. In order to help address this barrier, we have identified milestones/checkpoints to evaluate our progress along the way and we are also establishing a PRIME Analytics Workgroup to oversee all of the data collection work for PRIME's reporting requirements. If necessary, we have a contingency plan to prioritize PRIME metrics over other report requests and include an additional analyst to work on the measures.

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.*

San Mateo Medical Center's mission is to partner with patients to provide excellent care with compassion and respect. Our vision is that every patient will live the healthiest life possible. We have 5 overarching strategic organizational goals:

- Patient Centered Care: We focus on what matters most to our patients and their families and partner with them to provide compassionate care in a culturally competent way.
- Excellent Care: We partner with our patients to achieve their health goals by providing a safe environment and integrated, evidence-based care.
- Right Care, Time, Place: We ensure our patients get the right care at the right time and place.
- Staff Engagement: We are a great place to work and we are passionate about serving our community.
- Financial Stewardship: We partner with our patients to deliver high value care in a financially responsible manner.

Each of the nine PRIME projects serves to advance one or more of SMMC's Strategic Organizational Goals while providing an opportunity to provide extra focus and prioritization on ensuring we are serving our most vulnerable at-risk patients in a way that meets their health goals.

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.*

Each of SMMC's Organizational Goals is supported by at least one Strategic Initiative. Three of SMMC's Strategic Initiatives will serve as our overarching aims for our PRIME participation because they will be directly improved by our PRIME work. The Strategic Initiatives serving as our PRIME aims are:

1. Flow and Transition: The purpose of this initiative is to identify and measure constraints on patient flow and develop interventions to facilitate and expedite transitions to ensure patients are receiving the right care, at the right time, in the right place.
2. Patient Centered Medical Home: This initiative focuses on transforming our Health Centers to support population medicine utilizing patient-centered principles.
3. Financial Stewardship: This initiative focuses on optimizing managed care performance, management of productivity, and revenue cycle performance.

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;*

Our 9 PRIME projects align and support three of SMMC's strategic initiatives and their corresponding goals as follows:

a. *Flow and Transition Aim*: Care Transitions, Integration of Post-Acute Care, and Complex Care Management for High Risk Medical Populations.
b. *Patient Centered Medical Home Aim*: Ambulatory Redesign for Primary and Specialty Care, Integration of Behavioral Health and Primary Care, Cancer Screening and Follow-up, Integrated Health Home for Foster Children, and Chronic Non-Malignant Pain Management.
c. *Financial Stewardship Aim*: Resource Stewardship: High Cost Imaging

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);*

San Mateo Medical Center is building a patient centered medical home that is fully integrated with our Health System. All of the PRIME projects directly support our system transformation through the strengthening of our patient centered medical home and its connections to our systems of care. The PRIME work also directly supports San Mateo Medical Center's Pillar Goals and as a result we will be able to provide excellent patient centered care at the right time and in the right place for our patients.

5. *Provide a succinct summary description of how your hospital or health system will be transformed at the end of the five years. Explain how this transformation should result in advances in clinical, population health, fiscal or other critical outcomes through PRIME.*

By the end of the five years, every patient that SMMC serves will live the healthiest life possible. Our Primary Care Clinics will have achieved the ten building blocks essential to a patient centered medical home and clinic staff will be practicing at the top of their license (infrastructure improvement). We will have improved access to our Specialty Care Clinics and our Care Transitions Program will be fully implemented (infrastructure improvement). Patients admitted to our hospital will receive the right care at the right time and place (clinical improvement) and we will deliver high value care in a financially responsible manner (financial improvement). All SMMC staff will be fully engaged employees who partner with patients to provide them compassionate care in a culturally competent way.

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.

As we shared in section 2.1, the Needs Assessment outlined a need to improve healthy behaviors since only 5.4% exhibit them. Recognizing the challenges faced to engage in healthy behaviors and that obesity rates and risk factors for heart disease are increasing, we will build in policies and protocols to our system to ensure it is easier for patients to engage in healthy behaviors and disease prevention activities. The majority of these interventions will be delivered through our patient centered medical home. Specifically, through PRIME we will:

- Implement care coordination and case management for at risk medically complex patients.

- Develop a care transitions program to support our discharging patients to provide built in support during a medically critical period.
- Ensure patients receive preventive cancer screenings.
- Conduct depression screenings on a larger proportion of our patient population with a prioritization of those patients at higher risk for depression.
- Move from a reactive system to a proactive system where we are pro-actively screening our patients for depression. Ensure those screening positive for depression are linked to follow-up care for their depression.
- Ensure Well child-checks occur for our patients in Foster Care.
- Ensure HbA1c testing and control for diabetic patients to help them manage their diabetes.
- Promote smoking cessation for patients using tobacco.
- Promote flu vaccinations for patients.
- Screen patients for alcohol and drug misuse.
- Ensure chronic pain patients who are prescribed opioids have an opiod agreement in place and that we provide them with non-opioid pain management options.

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).

San Mateo Medical Center's governance strategy is through a Board of Directors, the Medical Executive Committee and the Executive Management Team. We have also established a Waiver Integration Team (WIT) to guide the development and implementation and evaluation of PRIME at San Mateo Medical Center. We are also in the process of establishing individual teams for each PRIME Project, a Data Analytics Workgroup to support all PRIME projects, and a Disparities workgroup to support all PRIME projects. San Mateo Medical Center has adopted LEAN as its primary performance improvement methodology (SMMC's version of LEAN is referred to as LEAP). As our PRIME work directly supports our organizational goals and strategic initiatives, LEAN approaches will be used to design test and implement our interventions. In addition, monitoring of the metrics will be included as part of our LEAN Tier Walls, PRIME project team meetings, and Executive Management Team meetings. Additionally, SMMC has been developing a Patient Centered Medical Home, this infrastructure will be utilized to support most of our PRIME projects.

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.

As part of our efforts to improve the patient experience, San Mateo Medical Center established a Patient and Family Advisory Committee. Patients serve as Improvement Partners on this Committee and meet on a monthly basis. In addition, there is a Patient and Family Steering Committee comprised of our Improvement Partners, Medical Center leadership, and staff. This Steering Committee meets every other month. Over the past year, we have formalized incorporation of Improvement Partner participation in our organizational improvement work. As an example of how we have put this into practice, our Improvement Partners serve on our LEAP (LEAN) events, help audit standard work for our clinics and patient call center, and are regularly sought out for input on our ongoing initiatives. We will continue to engage these stakeholders in our PRIME work.

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.

San Mateo Medical Center is dedicated to ensuring we partner with patients to provide compassionate care in a culturally competent way. This commitment is reflected in our Strategic Goal of Patient Centered Care through the following Goal language “Patient Centered Care: We focus on what matters most to our patients and their families, and partner with them to provide compassionate care in a culturally competent way.” San Mateo Medical Center is able to provide patients with interpreters in almost any language and is part of the Health Care Interpreter Network. We also have the capability to provide in-person interpreters for some languages. In our staff-wide” WE CARE” training, we promote being mindful of cultural beliefs and preferences. Our Physicians are also receiving an 8-hour Relationship Center Building training which promotes meeting the specific needs of each patient. We anticipate that as part of our newly formed organizational wide Disparities PRIME Workgroup, we will identify and address existing gaps in our organization’s cultural competence.

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.

Since 2009, San Mateo Medical Center has used Lean performance improvement methods adapted for health care as a way to improve quality and outcomes, increase cost effectiveness, support change management, and improve patient/client experience. As we continued to expand the work, the Chief of the Health System encouraged giving the LEAN program a name that accurately reflecting the process, reflects our goals, and was unique to our system. With input from staff, providers and leadership, we selected a new name for the Lean program: LEAP (an acronym for Learn, Engage, Aspire, Perfect). These verbs fully embody the transformation journey: engaging staff, patients and clients in creating a thriving community of continuous problem solvers who seek to deliver higher value services to our customers. All PRIME projects will be directly supported by our LEAP Institute in order to improve the PRIME related services we provide to our patients.

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

☒ 1.1 Integration of Physical and Behavioral Health (required for DPHs)

This PRIME project and the selected core components help bring together San Mateo Medical Center's (SMMC) Goals and helps meet our organizational mission

of partnering with patients to provide excellent care with compassion and respect. Aligning these core components of the project to our strategic initiatives serves to elevate our current work in these areas and unifies our efforts across the health system. Below we have outlined how the components of this PRIME project align with SMMC's Goals:

Patient Centered Care:

- Increasing access to behavioral health services.
- Incorporate patient engagement into design and implementation of projects.

Excellent Care:

- Utilization of a nationally recognized model of integrated physical-behavioral health (i.e. four quadrant model).
- Use of empirically based tools to assess patient's level of functioning related to their behavioral health or substance use disorder.

Staff Engagement:

- Utilizing a team based approach when managing patients with chronic diseases and helps bring the expertise of each team member to meet the patient's needs.

Right Care, Time, Place:

- The personal touch of the warm hand off helps patients navigate through the complex mental health system of the San Mateo Health System and get connected immediately to the correct clinic.
- Having Medication Assisted Treatment (MAT) services available to all clinics to address needs of substance use disorder patients in real time.

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

This PRIME project will help SMMC to utilize the full scope of its resources for our most vulnerable populations and we anticipate this work will facilitate systematic improvement. The PRIME project will also help us improve the services provided for specific patient populations with conditions that put them at greater risk for depression. For instance, for diabetic patients who are also depressed, we will utilize brief interventions in areas most troublesome for their diabetes management.

We will build upon our DSRIP behavioral health and primary care integration activities for this PRIME work. In our DSRIP work, we integrated behavioral health in two primary care clinics, Fair Oaks Health Center and the Innovative Care Clinic, in order to conduct depression screenings for our diabetic patients. We envision a

possible approach for this PRIME project would be to expand our depression screening to other patient groups in the Fair Oaks Health Center and Innovative Care Clinic that are at high risk for depression.

This project will also encourage us to find faster, more efficient methods of gathering patient data regarding emotional health screens. In order for us to increase our reach, the integration of technology will be vital to our success. We also anticipate that this PRIME project will make us better stewards of our resources by better matching them to patient needs. For example, we anticipate that we may tailor our treatment plans for patients to the level of care and frequency that is needed by that specific patient rather than prescribing a standard 10 sessions per patient. This tailoring based on clinical need will also help us ensure that patients are able to gain access to these services in a timely fashion so their behavioral health does not decline in any wait period. Our goal for this PRIME project is to develop and implement the chosen components so we can ultimately increase the patients' quality of life to allow them to live the healthiest life possible.

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

Check, if applicable	Description of Core Components
Applicable	**1.1.1** Implement a behavioral health integration assessment tool (baseline and annual progress measurement)
Applicable	**1.1.2** Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration, the Collaborative Care Model, or other Integrated Behavioral Health (IBH) resources from SAMHSA)
Not Applicable	**1.1.3** Integrate appropriate screening tools and decision support into the emergency department (ED) to ensure timely recognition of patients with mental health and substance use disorder problems. Enhanced access to primary care and/or to behavioral health specialists will be integrated into discharge planning for these patents. Use of 24-7 care navigators (e.g., Community Physician Liaison Program) may be used to support linkages to primary care providers (PCPs), mental health (MH) and substance use disorder (SUD) specialists and behavioral health and other community services through the discharge process.

Check, if applicable	Description of Core Components
Applicable	**1.1.4** Integrate physical and behavioral health, either through implementation of a new program or an expansion of an existing program, from pilot sites to hospital and health system primary care sites or from single populations to multiple populations (e.g., obesity, diabetes, maternal, infant, and child care, end-of-life care, chronic pain management).
Not Applicable	**1.1.5** Patient-Centered Medical Home (PCMH) and behavioral health providers will: • Collaborate on evidence based standards of care including medication management and care engagement processes. • Implement case conferences/consults on patients with complex needs.
Applicable	**1.1.6** Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families.
Applicable	**1.1.7** Ensure systems are in place to support patient linkages to appropriate specialty physical, mental and SUD services. Preventive care screenings, including behavioral health screenings (e.g., PHQ-2, PHQ-9, SBIRT), will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including the provision of brief interventions (e.g., motivational interviewing techniques) to ensure access for further evaluation and treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.
Applicable	**1.1.8** Provide cross-systems training to ensure effective engagement with patients with MH/SUD conditions. Ensure that a sufficient number of providers are trained in SBIRT and/or in other new tools used by providers to ensure effectiveness of treatment.
Applicable	**1.1.9** Increase access to Medication Assisted Treatment (MAT) for

Check, if applicable	Description of Core Components
	patients with alcohol and opioid addiction to assist in stabilizing their lives, reducing urges or cravings to use, and encourage greater adherence to treatment for co-morbid medical and behavioral health conditions. For alcohol use disorders these medications include naltrexone, acamprosate, and disulfiram. For opioid addiction, medication assisted treatment (MAT) includes maintenance treatment with methadone and buprenorphine.
Not Applicable	**1.1.10** Ensure the development of a single treatment plan that includes the patient's behavioral health issues, medical issues, substance abuse, social and cultural and linguistic needs. This includes incorporating traditional medical interventions, as well as non-traditional interventions such as gym memberships, nutrition monitoring, healthy lifestyle coaching, or access to culturally and linguistically appropriate peer-led wellness and symptom management groups.
Not Applicable	**1.1.11** Ensure a culturally and linguistically appropriate treatment plan by assigning peer providers or other frontline worker to the care team to assist with care navigation, treatment plan development and adherence.
Applicable	**1.1.12** Ensure that the treatment plan: • Is maintained in a single shared Electronic Health Record (EHR)/ clinical record that is accessible across the treatment team to ensure coordination of care planning. • Outcomes are evaluated and monitored for quality and safety for each patient.
Not Applicable	**1.1.13** Implement technology enabled data systems to support pre-visit planning, point of care delivery, care plan development, population/panel management activities, coordination and patient engagement. Develop programs to implement telehealth, eReferral/eConsult to enhance access to behavioral health services.
Applicable	**1.1.14** Demonstrate patient engagement in the design and implementation of the project.

Check, if applicable	Description of Core Components
Applicable	**1.1.15** Increase team 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.
Applicable	**1.1.16** Ensure integration is efficient and providing value to patients by implementing a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

☒ 1.2 Ambulatory Care Redesign: Primary Care (required for DPHs)

This PRIME project is directly aligned with SMMC's Patient Centered Medical Home Strategic Initiative. This initiative is focused on transforming our Health Centers to support population medicine utilizing patient-centered principles Last year SMMC's ambulatory care clinics all underwent the PCMH Assessment through a grant with the California Health Care Foundation. Our baseline results were available in August of 2015. We will be utilizing these assessment results to inform our work on the selected core components of our Ambulatory Care Redesign. We will also be utilizing our LEAP (LEAN) office as the performance improvement approach for this PRIME project and our first priority is care team transformation to achieve team-based care. This PRIME project will require close collaboration with the Integration of Physical and Behavioral Health PRIME project, the Specialty Care Redesign PRIME project, the Cancer Screening PRIME project and the Integrated Health Home for Foster Children PRIME project.

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

By undergoing this redesign in our ambulatory care services, SMMC will be able to increase access for our patients, improve staff engagement, and provide population medicine for our patients. The first crucial step to this transformation is our care team transformation. A component of this transformation is to allow

each member of our care team to perform to the top level of their credentials. We are also embarking on creating alternatives to face-to-face provider/patient visits through the use of phone based care, group visits, and nurse visits. Other essential components of this work will be the use of care coordination, population management, and care management for our most at-risk patients. Our goal is to create a pro-active integrated patient centered delivery system and this PRIME project directly supports our work.

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.
Not 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.
Not 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.

Check, if applicable	Description of Core Components
	• 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. • 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.
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)).

Check, if applicable	Description of Core Components
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. • 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.

☒ 1.3 Ambulatory Care Redesign: Specialty Care **(required for DPHs)**

Just as our patients do not see themselves in terms of one disease or one discrete organ system, so too San Mateo Medical Center (SMMC) does not envision our care as limited to one specialty encounter or siloed delivery of care. This PRIME project will fuel and enhance our ongoing efforts to transform specialty care. Through working with our primary care and public health colleagues, we aim to establish a patient-centered specialty care program that recognizes the unique role of specialty services, while also creating a more seamless care continuum. We will work with our LEAP (LEAN) Institute to develop and implement improvement events centered on

the Specialty referral process and related care communication. We recognize that tracking and coordinating referrals is paramount for building stronger linkages between primary care and specialty care for our patients. Similarly, moving toward shared planning and managing of patient care will create more meaningful care integrations. By focusing on closed loop communication about specialty care requests and visits, mutually agreed upon care protocols, and continuous performance evaluation and improvement, we seek to establish both vertical alignment across public health and primary and specialty ambulatory care, as well as horizontal alignment among our specialty clinics.

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

As an innovative, integrated care facility, San Mateo Medical Center has been at the forefront of adopting and adapting new ways to meet the comprehensive health care needs of our patient population. In particular, we see ambulatory specialty care as an area where SMMC can make further improvements for our patients. Patients with multiple chronic diseases or complex conditions often need specialty care that is not on the periphery, but rather a central partner with primary care, public health, and the patients themselves. This PRIME project will enable SMMC to pursue specialty care redesign and create that partnership for our patients through improved communication, care transitions, care planning, and care coordination. Moreover, this PRIME project supports SMMC's efforts to conduct continuous performance tracking and quality improvement, which in turn ensures that SMMC is always aware of what is working and what can work better for our patients throughout the process of specialty care transformation.

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

Check, if applicable	Description of Core Components
Applicable	**1.3.1** Develop a specialty care program that is broadly applied to the entire target population.
Not Applicable	**1.3.2** Conduct a gap analysis to assess need for specialty care including mental health and SUD services (analysis to include factors impacting ability to access specialty care), and the current and ideal state capacity to meet that need. Benchmark to other CA Public Health Care systems.

Check, if applicable	Description of Core Components
Not Applicable	**1.3.3** For ideal state analysis, include potential impact of increased primary care capacity to manage higher acuity conditions either independently, or in collaboration with, specialty care, so as to reduce the need for in-person specialty care encounters (e.g., insulin titration, IBS management, joint injections, cognitive behavioral therapy (CBT) or MAT).
Applicable	**1.3.4** Engage primary care providers and local public health departments in development and implementation of specialty care model.
Applicable	**1.3.5** Implement processes for primary care/specialty care co-management of patient care.
Applicable	**1.3.6** Establish processes to enable timely follow up for specialty expertise requests.
Applicable	**1.3.7** Develop closed loop processes to ensure all requests are addressed and if in person visits are performed, that the outcome is communicated back to the PCP.
Not Applicable	**1.3.8** Ensure that clinical teams engage in team- and evidence-based care.
Applicable	**1.3.9** Increase 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 care model.
Applicable	**1.3.10** Develop and implement standardized workflows for diversified care delivery strategies (e.g., shared medical visits, ancillary led services, population management, telemedicine services) to expand access and

Check, if applicable	Description of Core Components
	improve cost efficiency.
Applicable	**1.3.11** Adopt and follow treatment protocols mutually agreed upon across the delivery system.
Not Applicable	**1.3.12** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population management activities and care coordination/transitions of care. Ensure that timely, relevant, and actionable data are used to support patient engagement, PCP collaboration, and drive clinical, operational and strategic decisions including continuous quality improvement (QI) activities.
Not Applicable	**1.3.13** Implement EHR technology that meets MU standards.
Applicable	**1.3.14** Patients have care plans and are engaged in their care. Patients with chronic disease (including MH/SUD conditions) managed by specialty care have documented patient-driven, self-management goals reviewed at each visit.
Not Applicable	**1.3.15** Improve medication adherence.
Applicable	**1.3.16** Implement population management strategies for patients in need of preventive services, with chronic conditions, or with recurring long term surveillance needs.
Not Applicable	**1.3.17** Implement or expand use of telehealth based on DPH/DMPH capacity to address patient and PCP barriers to accessing specialty expertise. Implement a telehealth platform with communication modalities that connect between specialty care and primary care (e.g., eConsult/eReferral).
Not	**1.3.18** Demonstrate engagement of patients in the design and

Check, if applicable	Description of Core Components
Applicable	implementation of the project.
Applicable	**1.3.19** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.
Not Applicable	**1.3.20** Test use of novel performance metrics for redesigned specialty care models.

☒ 1.6 – Cancer Screening and Follow-up

SMMC selected this project because not only does it build on our prior mammography work for DSRIP, but it also fully leverages the power of the Patient Centered Medical Home. By selecting this project we will be able to build on our past DSRIP mammography work in order to expand these past achievements and lessons learned to a greater variety of cancer screenings. As part of our DSRIP mammography improvement work we utilized a LEAN approach when designing and implementing our intervention and this performance improvement strategy will be an essential component of this PRIME project. We anticipate that our main body of work to implement this project will be based on our prior mammography work where we used LEAN approaches to develop standard work, care processes and protocols. As part of this work, we engaged patients to ensure our solutions were appropriate and would be successful. In addition, once we receive our baseline data, our multi-disciplinary team will identify any gaps in care and determine if the solution of developing standard work, care processes and protocols will address these gaps. We also envision that we will conduct outreach activities and employ members of the care team to review and contact patients either in writing or by phone to provide coaching and instructions. We will also utilize clinical alerts embedded in our EHR as well as daily huddles to include this screening review with patients. Additionally there may be educational campaigns in a more general way to improve patient awareness. If these solutions are not sufficient to address the identified gaps in care, we will likely employ LEAN strategies to identify appropriate solutions. Another essential component will be collaboration using a multi-disciplinary task force to lead and champion this work. We will rely on national standards to inform the development of the care processes and protocols that will standardize our cancer screening work. These interventions will be implemented and delivered through our Patient Centered Medical Home. This project will also rely on close collaboration with our PRIME Primary Care Redesign Project work.

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

As we move forward in our transformation, San Mateo Medical Center aims to move from being a reactive health care system to a proactive health care system. This PRIME work will enable us to develop a system and processes to standardize the screening of our patients for preventative exams. The model that is developed for our Cancer Screening PRIME work could then be expanded for other preventative screening exams. By ensuring that we are providing these proactive screenings and reaching out to the patients to ensure the screenings

are completed we will be able to detect and treat disease earlier for our patients and thus enable them to live healthier lives.

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

Check, if applicable	Description of Core Components
Applicable	**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: o Enterprise-wide standard approach to screening (e.g., ages, frequency, diagnostic tool). • Follow-up for abnormal screening exams: o Clinical risk-stratified screening process (e.g., family history, red flags). Timeliness (specific time benchmark for time from abnormal screening exam to diagnostic exam).
Applicable	**1.6.2** Demonstrate patient engagement in the design and implementation of programs.
Not Applicable	**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.
Applicable	**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.
Applicable	**1.6.5** Improve access to quality care and decrease disparities in the delivery of preventive services.
Applicable	**1.6.6** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated

Check, if applicable	Description of Core Components
	disparities, and improving population health.
Applicable	**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.
Not Applicable	**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.
Applicable	**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 (Select At Least 1):	**1**	
Domain 1 Total # of Projects:	**4**	

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

☒ 2.2 – Care Transitions: Integration of Post-Acute Care **(required for DPHs)**

The Care Transition project will provide effective approaches to better support “at risk” community members in understanding and managing their health conditions, accessing the vast array of community services that can help prevent an expensive health crisis(e.g. hospitalization and/or institutionalized care), and transitioning safely home when hospitalization does occur. The priority population for this PRIME project will be patients who are 50 years and older with any combination of the following: multiple medical issues and on multiple medications, multiple hospital admissions and/or readmissions, live at home with limited or no family or community support, or require assistance with Activities of Daily Living.

In order to support our patients in their transition from in-patient to out-patient care, we have identified the following objectives for this program 1) Medication reconciliation and self-management: make sure patients have access to pharmacies, can afford their prescriptions, know how to take their medications and understand the drugs’ purpose and potential side effects, 2) Physician follow-up: making sure the patients know when to see the primary or specialty physicians for follow-up care, that such visits are scheduled and that the patient has needed transportation, 3) Nutrition and 4) Home safety: making sure the patient has adequate healthy foods so that malnutrition does not impair the recovery, checking the home for hazards that can lead to falls or other injuries , and 5) Working with the patient so they know and recognize red flags that indicate a worsening of their health conditions and ensuring the patient knows what to do to get help.

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

As SMMC moves from fee for service to a value-based care model, a properly designed care transitions and care management program will significantly enhance the patient care experience and associated clinical and process outcomes. Our goal is to ensure that the relevant transitions and care management services are provided to the patient at the appropriate time and place.

We anticipate that patients enrolled in the program will be less likely to be readmitted to the hospital. Rather than simply managing post-hospital care in a

reactive manner, we will be partnering with our patients to impart self-management skills that will continue to benefit the patient long after they graduate from the transition program. Patients who receive this program will be more likely to connect with their primary care provider shortly after their in-patient admission and achieve self-identified personal goals around symptom management and functional recovery. This program aims to prevent readmissions, addresses the needs of older adults with health conditions, reduce medical costs, provide a safety net for older adults in isolation and address the lack of resources (e.g. emotional, social and financial). We envision that SMMC's Transitions of Care program will be focused on improved care coordination across the health care delivery system to help ensure seamless transition of patients between home based care, primary care, specialty care and hospital-based settings.

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

Check, if applicable	Description of Core Components
Applicable	**2.2.1** Develop a care transitions program or expand a care transitions program to additional settings (e.g., emergency department), or to additional populations, using or adapting at least one nationally recognized care transitions program methodology.
Applicable	**2.2.2** Establish or expand on a system to track and report readmission rates, timeliness of discharge summaries, and other transition processes, and investigate system-specific root causes/risk factors for readmission, using quantitative and qualitative information to identify the key causes of readmissions, including physical, behavioral and social factors.
Applicable	**2.2.3** Develop and implement a process, including utilization of data and information technology, to reliably identify hospitalized patients at high-risk for readmission.
Not Applicable	**2.2.4** Develop standardized workflows for inpatient discharge care: • Optimize hospital discharge planning and medication management for all hospitalized patients. • Implement structure for obtaining best possible medication history and for assessing medication reconciliation accuracy. • Develop and use standardized process for transitioning patients to sub-acute and long term care facilities.

Check, if applicable	Description of Core Components
	• Provide tiered, multi-disciplinary interventions according to level of risk: o Involve mental health, substance use, pharmacy and palliative care when possible. o Involve trained, enhanced IHSS workers when possible. o Develop standardized protocols for referral to and coordination with community behavioral health and social services (e.g., visiting nurses, home care services, housing, food, clothing and social support). Identify and train personnel to function as care navigators for carrying out these functions.
Not Applicable	**2.2.5** Inpatient and outpatient teams will collaboratively develop standardized transition workflows: • Develop mechanisms to support patients in establishing primary care for those without prior primary care affiliation. Develop process for warm hand-off from hospital to outpatient provider, including assignment of responsibility for follow-up of labs or studies still pending at the time of discharge.
Not Applicable	**2.2.6** Develop standardized workflows for post-discharge (outpatient) care: • Deliver timely access to primary and/or specialty care following a hospitalization. • Standardize post-hospital visits and include outpatient medication reconciliation.
Applicable	**2.2.7** Support patients and family caregivers in becoming more comfortable, competent and confident in self-management skills required after an acute hospitalization by providing: • Engagement of patients in the care planning process. • Pre-discharge patient and caregiver education and coaching. • Written transition care plan for patient and caregiver. • Timely communication and coordination with receiving practitioner. Community-based support for the patient and caregiver post hospitalization focusing on self-care requirements and follow-up care with primary and specialty care providers.

Check, if applicable	Description of Core Components
Applicable	**2.2.8** Engage with local health plans to develop transition of care protocols that ensure: coordination of care across physical health, substance use disorder and mental health spectrum will be supported; identification of and follow-up engagement with PCP is established; covered services including durable medical equipment (DME) will be readily available; and, a payment strategy for the transition of care services is in place.
Not Applicable	**2.2.9** Demonstrate engagement of patients in the design and implementation of the project.
Not Applicable	**2.2.10** Increase multidisciplinary team 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.
Not Applicable	**2.2.11** Implement a system for continual performance feedback and rapid cycle improvement that uses standard process improvement methodology and that includes patients, front line staff and senior leadership.

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

In the initial stages of this project, we will focus on using our clinical data sources to identify high-risk patients who would benefit from this work. Our initial focus will be to determine if we need to specify a required chronic condition for any of the 4 chronic conditions. After this initial data analysis, our program planning approach will likely be modeled on our current collaboration with Stanford Health Care and the Health Plan of San Mateo on Emergency Department high utilizers. We have been using LEAN methodology and tools to develop the initial framework for this collaboration and our current A3 for the project will be used to inform the PRIME Complex Care project. We will also base our program approach on existing best practices and the evidence based literature.

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

   This project aligns with San Mateo Medical Center's Flow and Transition Strategic Initiative and its goal to ensure our patients receive the right care, at the right time, in the right place. The benefit of this PRIME project is that it will allow us to focus on our most complex, high-risk patients and to develop a system of care to better support them. This project will also benefit from close collaboration with our PRIME Primary Care project, PRIME Specialty Care project, and PRIME Care Transitions project. In addition to being better able to care for those patients who are currently medically high-risk, we also envision moving towards a proactive system that is able to identify patients at risk for becoming high-risk and support them before they are in crisis.

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

Check, if applicable	**Description of Core Components**
Applicable	**2.3.1** Develop a complex care management program at one site or with one defined cohort, or expand an existing program from a pilot site to all sites or to additional high-risk groups and demonstrate engagement of patients in the design and implementation of the project.
Not Applicable	**2.3.2** Utilize at least one nationally recognized complex care management program methodology.
Applicable	**2.3.3** Identify target population(s) and develop program inclusion criteria based on quantitative and qualitative data (e.g., acute care utilization, lack of primary care utilization, number of high-risk medical mental or SUD conditions, polypharmacy, primary care input, functional status, patient activation, social support or other factors). Include patient factors associated with a higher probability of being impacted by complex care management.
Applicable	**2.3.4** Conduct a qualitative assessment of high-risk, high-utilizing patients.
Applicable	**2.3.5** Establish data analytics systems using clinical data sources (e.g., EHR, registries), utilization and other available data (e.g., financial, health plan, zip codes), to enable identification of high-risk/rising risk patients for targeted complex care management interventions, including

Check, if applicable	Description of Core Components
	ability to stratify impact by race, ethnicity and language.
Not Applicable	**2.3.6** Develop a multi-disciplinary care team, to which each participant is assigned, that is tailored to the target population and whose interventions are tiered according to patient level of risk.
Applicable	**2.3.7** Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets.
Not Applicable	**2.3.8** Implement evidence-based practice guidelines to address risk factor reduction (smoking cessation/immunization/substance abuse identification and referral to treatment/depression and other behavioral health screening, etc.) as well as to ensure appropriate management of chronic diseases: • Use standardized patient assessment and evaluation tools (may be developed locally, or adopted/adapted from nationally recognized sources). Use educational materials that are consistent with cultural, linguistic and health literacy needs of the target population.
Applicable	**2.3.9** Ensure systems and culturally appropriate team members (e.g. community health worker, health navigator or promotora) are in place to support system navigation and provide patient linkage to appropriate physical health, mental health, SUD and social services. Ensure follow-up and retention in care to those services, which are under DPH/DMPH authority, and promote adherence to medications.
Not Applicable	**2.3.10** Implement technology-enabled data systems to support patients and care teams throughout the care management program including patient identification, pre-visit planning, point-of-care delivery, care plan development and population/panel management activities.
Applicable	**2.3.11** Implement a data-driven system for rapid cycle improvement and performance feedback to address quality and safety of patient care, which includes patients, front line staff and senior leadership.

☒ 2.4 – Integrated Health Home for Foster Children

We selected this project because of SMMC's recognition that children in foster care are at higher risk for medical and mental health conditions. In order to implement this project, we will convene an interdepartmental, interdisciplinary committee to champion the PRIME Integrated Health Home for Foster Children work. We will be partnering with San Mateo's Children and Family Services Division in order to ensure we are working collaboratively to improve our care of the foster children in our system. Our initial step will be to identify the foster children in San Mateo's Children and Family Services system who are assigned to San Mateo Medical Center. Once these children are identified, we will develop and implement a coding in our medical record to allow the SMMC care teams to be able to easily identify if a child is in foster care. We also plan to look at available resources for foster children and evaluate our current processes related to these resources. We will identify care team leads to ensure foster children receive their necessary screenings and exams in the recommended time period. We also plan to build a template in our medical record for foster children so during their exams the care team can ensure they receive any applicable screenings and exams. We will also be training the whole care team on how to perform the different foster child exam components. We also envision that we will work with other agencies such as the San Mateo County Behavioral Health, the School Districts and Lucile Packard Children's Hospital to ensure coordinated care across service lines and locations.

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

SMMC recognizes that children in foster care are at higher risk for medical and mental health conditions. In our current care system, SMMC has no way to easily signal which children are in foster care and to prompt care team outreach to patients not seen every year. This PRIME work will allow us to build a system to help bring foster children in for their regular screenings and exams. This work will also increase SMMC's pediatric care teams' knowledge of the specific screening and exam needs for foster children. We envision that our collaboration with other divisions in our health system will allow us to improve information sharing so that for each foster child we have the full scope of the other services they are receiving in our health system. This information sharing will also allow us to improve our coordination of care and linkages to resources and services such as behavioral health and specialty medical care as well as educational support for children in foster care.

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

Check, if applicable	Description of Core Components
Applicable	**2.4.1** Healthcare systems receive support in the ongoing management and treatment of foster children: Demonstrate engagement of patients and families in the design and implementation of this project.
Not Applicable	**2.4.2** Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration).
Applicable	**2.4.3** Multi-therapeutic care team will: • Identify patient risk factors using a combination of qualitative and quantitative information. • Complete a patient needs assessment using a standardized questionnaire. • Collaborate on evidence-based standards of care including medication management, care coordination and care engagement process. • Implement multi-disciplinary case conferences/consults on patients with complex needs. • Ensure the development of a single Treatment Plan that includes the patient's behavioral health issues, medical issues, substance abuse and social needs: o Use of individual and group peer support. • Develop processes for maintaining care coordination and "system continuity" for foster youth who have one or more changes in their foster home. • Ensure that the Treatment Plan is maintained in a single shared EHR/clinical record that is accessible across the treatment team to ensure coordination of care planning. • Assess and provide care for all routine pediatric issues with a specific focus on: o Mental health/toxic stress o Obesity o Chronic disease management o Medication/care plan adherence which are vulnerable when kids transition care givers frequently o Substance abuse issues Developmental assessment, identification and treatment
Not Applicable	**2.4.4** Implement technology-enabled data systems to support pre-visit planning, point-of-care delivery, population/panel management activities

Check, if applicable	Description of Core Components
	and care coordination. Timely, relevant and actionable data is used to support patient engagement, and drive clinical, operational and strategic decisions including continuous QI activities.
Applicable	**2.4.5** Provide linkages to needed services that at a minimum includes child welfare agency, mental health, substance abuse and public health nursing as well as any other social services that are necessary to meet patient needs in the community.
Applicable	**2.4.6** Develop liaisons/linkage with school systems.
Not Applicable	**2.4.7** Provide timely access to eligibility and enrollment services as part of the health home services.
Applicable	**2.4.8** Evidence-based practice guidelines will be implemented to address risk factor reduction (e.g., immunization, smoking cessation, behavioral health screening) as well as to ensure appropriate management of chronic diseases (e.g., asthma, diabetes). Assessment of social service needs will be integral to these activities. Educational materials will be utilized that are consistent with cultural and linguistic needs of the population.
Not Applicable	**2.4.9** 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.

☒ 2.6 – Chronic Non-Malignant Pain Management

In March of 2016, the CDC published guidelines regarding safe opioid prescribing. These guidelines were produced in response to several challenging issues facing medical providers today. Chronic pain is a condition affecting increasing numbers of patients. In the US, we have seen increasing narcotic prescriptions despite evidence that they are of limited efficacy in patients who are not suffering from cancer. In addition, we are facing a virtual epidemic of opioid related deaths. In response to the same factors listed above, San Mateo Medical Center established a pain management program in November of 2013. Led by a multidisciplinary team that included providers and staff from primary care, specialty care, behavioral health, the emergency department and pain management; this group designed interventions that align very well with the recently published CDC guidelines. This PRIME project will allow SMMC to build on this strong foundation and spread proven approaches to all its chronic pain patients. Utilizing LEAN methodologies, the organization will spread evidence based interventions such as pain agreements, multimodal pain therapy and proactive screening for patients at risk for abuse. Implementing these workflows as standard work in the Patient Centered Medical Home will allow the organization to reach more of its eligible patients.

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

This PRIME project will improve the care of SMMC patients with chronic pain in several ways. First, the program aims to reduce the inappropriate initiation of opioid therapy that might lead to long term use. As outlined above, the long term use of opioid therapy can frequently lead to addiction and even death. SMMC's patients will also benefit from regular screening to identify those who are at higher risk for addiction and abuse so that providers can avoid opioid use in this population. The use of other treatment modalities and non-narcotic pain medications will improve pain control and again avoid inappropriate and unnecessary opioid use. For those patients who are already on opioid therapy, the use of pain agreements, urine toxicology screens and the regular use of the prescription drug monitoring program will promote the safe use and monitoring of opioid therapy. All of these interventions will help patients to avoid unnecessary risk and live healthier lives.

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

Check, if applicable	Description of Core Components

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.
Not 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.
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.
Applicable	**2.6.8** Determine population ICD-9/ICD-10 codes for data collection that is

Check, if applicable	Description of Core Components
	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.
Applicable	**2.6.10** Establish a policy for monitoring and maintaining opioid agreements for prescription refills with other clinics, pharmacies, dentists and specialists.
Not 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.
Not Applicable	**2.6.12** Develop staff and clinician training regarding the organization's process for managing patients with chronic non-malignant pain.
Not 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.
Not Applicable	**2.6.14** Develop and implement protocols for prescribing naloxone to patients receiving opioids for chronic pain.
Not 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.

Check, if applicable	Description of Core Components
Not 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 chart:

	For DPHs	For DMPHs
Domain 2 Subtotal # of DPH-Required Projects:	**2**	**0**
Domain 2 Subtotal # of Optional Projects (Select At Least 1):	**2**	
Domain 2 Total # of Projects:	**4**	

Section 4.3 – Domain 3: Resource Utilization Efficiency

☒ 3.2 – Resource Stewardship: High Cost Imaging

SMMC selected this PRIME project due to an increasing number of orders for imaging studies and overutilization of many modalities within Radiology. This creates several issues. First it leads to a potential waste of resources. In addition, the inappropriate use of imaging resources can lead to delays or limited access for those patients who actually require these imaging studies. .SMMC will identify a core High Cost Imaging Project Core Team which consists of staff physicians, line staff, management, administration and patients. This team will design and implement a program that explores the root causes of high cost imaging and remedies the current situation. Working with our business intelligence office, we will gather baseline data on the chosen metrics. After the initial data collection, we will analyze the reasons for high cost imaging and overutilization. This analysis will provide us with the information we need to effect change. Change will happen on an organizational level that will rely on leadership from all the individuals comprising the High Cost Imaging Project Core Team.

Our initial priority population for each of the projects identified above will be based on the Project Specifications and Eligible Population. However, upon receipt of our baseline data we may decide to prioritize certain high-risk populations. For example, we may choose to focus first on our patients diagnosed with chronic pain because their use of Radiology services may be higher than other patient populations.

We envision that our implementation approach for this project will initially be based on ensuring engagement for developing new protocols and ordering practices from our Radiologists. Our next step will probably be to seek feedback and support on the development of these protocols and ordering practices from our Emergency Department Physicians. Once the ED Physicians and Radiologists are comfortable with any new protocols or ordering practices that are developed, we would implement the new processes in our ED. Lastly, we will also need to engage our Primary Care and Specialty Care Medical Directors and gather their feedback on the new ordering practices from Primary Care and Specialty Care for low-back pain imaging. Once the Primary Care and Specialty Care Medical Directors are supportive, we will also educate Primary Care Providers and Specialty Care Providers on the new ordering practices for low-back pain.

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

This PRIME project will enable SMMC to improve the quality of care for our patients by decreasing costs and ensuring proper utilization of the organization's imaging resources. By decreasing the number of "unnecessary" imaging studies, we will save the patients any unneeded radiation exposure along with their valuable time that it takes to complete these imaging studies. With decreased overutilization studies, this will enable our Radiology Department to devote a greater focus to the appropriately ordered patient imaging exams. In addition, the structure and approach for this project will give SMMC a template that it can follow in the future for similar resource utilization issues.

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

Check, if applicable	Description of Core Components
Applicable	**3.2.1** Implement an imaging management program, demonstrating engagement of patients in the design and implementation of components of the project.
Applicable	**3.2.2** Program should include identification of top imaging tests whose necessity should be assessed for possible overuse. Criteria for assessment could include: • Frequency and cost of inappropriate/unnecessary imaging: o Appropriate Use: Beginning with state- or nationally-recognized models or guidelines (e.g., American College of Radiology Appropriateness Criteria, American College of Cardiology Appropriate Use Criteria) and incorporating pertinent local factors, programs will set out definitions for appropriateness. o Cost: Programs will identify imaging studies associated with high costs due to high cost per study or high volume across the system. • Unwarranted practice variation within the participating DPHs/DMPHs. Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed. • Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed. • Whether there are established, tested and available evidence-based clinical pathways to guide cost-effective imaging choices.

Check, if applicable	Description of Core Components
Applicable	**3.2.3** Establish standards of care regarding use of imaging, including: • Costs are high and evidence for clinical effectiveness is highly variable or low. • The imaging service is overused compared to evidence-based appropriateness criteria. Lack of evidence of additional value (benefits to cost) compared to other imaging options available to answer the clinical question.
Not Applicable	**3.2.4** Incorporate cost information into decision making processes: • Develop recommendations as guidelines for provider-patient shared decision conversations in determining an appropriate treatment plan. • Implementation of decision support, evidence-based guidelines and medical criteria to recommend best course of action.
Applicable	**3.2.5** Provide staff training on project components including implementation of recommendations, and methods for engaging patients in shared decision making as regards to appropriate use of imaging.
Not Applicable	**3.2.6** Implement a system for continual rapid cycle improvement and performance feedback that includes patients, front line staff and senior leadership.

Please complete the summary chart:

	For DPHs	For DMPHs
Domain 3 Subtotal # of Selected Projects (Select At Least 1):	**1**	
Domain 3 Total # of Projects:	**1**	

Section 5: Project Metrics and Reporting Requirements

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

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

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

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

Section 6: Data Integrity

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

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

Section 7: Learning Collaborative Participation

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

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

Section 8: Program Incentive Payment Amount

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

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

- DY 11 $ 41,839,000DY 12 $ 41,839,000
- DY 13 $ 41,839,000
- DY 14 $ 37,655,100
- DY 15 $ 32,006,835

Total 5-year prime plan incentive amount: $ 195,178,935

Section 9: Health Plan Contract (DPHs Only)

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

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

Section 10: Certification

☒ I hereby certify that all information provided in this Plan is true and accurate to the best of my knowledge, and that this plan has been completed based on a thorough understanding of program participation requirements as specified in Attachment Q and Attachment II of the Waiver STCs.

Appendix- Infrastructure Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
1.				
2.				
3.				
4.				
5.				