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

Application due: 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

Tahoe Forest Hospital District

Health Care System Designation (DPH or DMPH)

DMPH

Section 2: Organizational and Community Landscape

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

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

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

Tahoe Forest Hospital District (TFHD) has two hospitals; one in California and the other in Nevada. For the purpose of the PRIME program TFHD will be looking at the service area that includes portions of five California counties; Nevada, Placer, Sierra, Plumas and El Dorado which are defined as Rural or Frontier according to the Office of Statewide Health Planning and Development. Additionally, TFHD is designated with Health Professions Shortage Areas (HPSAs) for Primary Care and Mental Health in addition to one county (Sierra) with a partial Medically Underserved Area (MUA) designation.

Physical Health: The most significant health issues facing our community include cardiovascular disease, substance abuse and mental health.

Cardiovascular disease indicators in our defined region surpass state averages. The prevalence of adult obesity is on par or exceeds the California average in 3 counties (Appendix- Table 1). County health data reveals an increased incidence of smoking, obesity and excessive drinking in our service area (Appendix- Table 1). The 2014 Community Health Needs Assessments (CHNA) Behavioral Risk Factor Surveillance System (BRFSS) survey data identified that 24% have high blood cholesterol, 26% have Hypertension and 81% have consumed alcohol in the last 30 days (Appendix- Graphs 1-3).

Behavioral Health: In 4 of our 5 counties, the ratio of people to mental health providers exceeds the State average (Appendix- Table 1). Across the 5 counties an average of 15% of adults are depressed which exceed the state average of 13.9 % (Appendix- Table 2). Strikingly, the drug overdose mortality rate is higher than 20 per 100,000 population in 4 of the 5 counties served. This is nearly double the California average. In the five TFHD counties, alcohol-impaired driving deaths are 1.2 times higher than the state average (Appendix- Table 3).

Health Disparities: The 2014 CHNA survey showed the Hispanic population in the region is in poorer health and has less access to care. Hispanics are one of the subgroups for which diabetes prevalence is highest[i]. Health disparities are significant in our catchment population. Eleven percent of the Caucasian population does not have health insurance, while 31% of the Hispanic population is uninsured (Appendix- Graph

4). Focus group interviews revealed difficulties with transportation, accessing care, cost of care for borderline Medi-Cal eligibility, lack of specialty providers- specifically affordable mental and behavioral health providers, immigration status as a concern in accessing care and other language and cultural barriers.

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.

Tahoe Forest Hospital serves a full-time population of approximately 35,000 residents. Travel to the nearest metropolitan area in California is approximately two hours and requires going over a 7,200 foot mountain pass. Travel can be hazardous and sometimes impassable during the winter season. Truckee has been historically underserved due to the remote geographical location and extreme climate conditions.

- **Income**: Per capita income in 2013 - $35,773. The percent of poor (< 100% Federal Poverty Level (FPL) is 8.9%, and near poor (100-199% FPL) is 25.0%. The median household income is $72,159[ii].
- **Race**: The TFHD region's population is roughly 19% Hispanic and 80% Non-Hispanic. The 2010 US Census indicated a nearly 50% increase in the Hispanic population from the 2000 Census. e.g. Kings Beach (49.3%) + Tahoe Vista (36.8%) + Placer County, and Truckee (17.4%). Ninety percent (90%) of the Caucasian population has health insurance, while only one third of the Hispanic population is insured.
- **Primary language**: English
- **Age**: The age mix is 20.0% under 18 years old; 70.0% 18 – 64 years old, and 9% are 65 years or older. Truckee median age is 38[iii] .
- **Government Program**: 38.5% of 2014/2015 TTUSD (Truckee Tahoe Unified School District) students received free or reduced price lunch.[iv]

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.

Tahoe Forest Hospital District is a 25-bed Critical Access Hospital licensed in the State of California and has a 24-hour emergency department, diagnostic imaging, ICU, ambulatory surgery and obstetrics units. TFHD provides a pain clinic through the ambulatory surgery department that includes anesthesia treatment modalities and some chronic pain management. Outpatient departments include Home Health, Hospice, Skilled Nursing Facilities (SNF), and Therapy Services. The Multi-

Specialty Clinics (MSC) offer primary care and other subspecialties but do not include a designated pain or psychiatric specialty. The subspecialists that cover these clinics also cover general internal medicine. Some of the practice sites include mid-level practitioners.

TFHD MSC includes 8 clinics and 25 Medical Providers (several physicians have multiple board subspecialties):

1. Internal Medicine/Cardiology/Neurology
2. Internal Medicine/Pulmonology/Sleep
3. Health Clinic/Occupational Health
4. Pediatric Clinic
5. Cancer Center: Medical Oncologists & Radiation Oncologists
6. Sports Medicine: Sports Medicine Practitioner
7. Ear, Nose and Throat clinic/ Audiology
8. Surgical/Gastroenterology Services
9. Cardiac Rehab (not a covered MediCal Benefit)

TFHD Payer Mix December 2015 is as follows:

- Medicare 36.4%
- Medi-Cal 16.7%
- Commercial 43%
- Other 3.8%

Key Tahoe Forest Hospital District Statistics January 1, 2015-December 31, 2015:

- Acute Patient Days: 4,248
- Observation Patient Days: 291
- Newborn Deliveries: 380
- ED visits: 13,500
- Outpatient Visits (>18 years old): 30,337

2.4 Baseline Data. *[No more than 300 words]*

Describe the current resources that your entity has in place to collect, report and monitor performance data and how these resources will support PRIME clinical quality reporting requirements. Please specify any anticipated limitations or barriers to meeting the PRIME reporting requirements and describe your proposed strategies to address these barriers.

Data Collection: TFHD utilizes several Electronic Health Records (EHRs) which have improved our capability to quickly access and analyze baseline and performance data.

Data is captured and entered into the EHR during all stages of the patients visit. This same EHR system will support PRIME efforts around data collection.

Data Reporting: Clinical quality data and other measureable metrics are collected and aggregated by a team of Clinical Informatics Analysts. Unfortunately, a few of the EHR's have rudimentary reporting capabilities, requiring a SQL programmer to retrieve the data. Staff is currently being trained in SQL programming to address this obstacle.

Data Monitoring: These metrics are monitored through a continuous process involving the use of dashboards reviewed regularly by the Board of Directors. Individual department metrics are guided by national benchmarks. All these measures help support innovation, data management, performance improvement, proactive risk assessment, commitment to customer satisfaction, and patient safety. The information provided in reports or dashboards can be used to identify areas where rapid cycle improvement projects will be most effective to improve the patient experience, improve overall population health and reduce costs. This monitoring process will be critically important to ensuring that the PRIME projects are effectively making improvements.

Potential Barriers: Multiple EHRs pose limitations. For example, medication agreements for chronic pain patients are housed in the outpatient EHR which is different than the Emergency Department (ED) EHR. This requires additional personnel to access patient information in various programs and adapt processes to ensure quality follow up care. As a result of these electronic records transitions, tracking data over a long period of time makes comparative analysis challenging. To overcome these obstacles and barriers a new Health System EHR platform will enable a unified patient record for both inpatient and outpatient within the next 18 months.

Section 3: Executive Summary

The objective of PRIME is to accelerate participating entities' efforts (as applicable), to change care delivery, to maximize health care value and to strengthen their ability to successfully perform under risk-based Alternative Payment Methodologies (APMs). This section of the Plan will be used to review each entity's overall goals and objectives. This section should also describe how these efforts will evolve over the course of the five years.

3.1 PRIME Project Abstract [No more than 600 words]

Please summarize the goals and objectives for your 5-year PRIME Plan. Include specific information, including:

3.1.1 Organizational goals and objectives that will support delivery system transformation

TFHD developed goals to integrate healthcare reform in the rural setting by incorporating the Triple Aim philosophy into everyday patient practices. A new vision statement; "*We exist to make a difference in the health of our communities through excellence and compassion in all we do*" and goals that were recently approved by the TFHD Board of Directors directly aligns with this new model of care.

Goals to support this new model include:

1. Align and integrate Physician Practices for sustainability and "Best Practice" models.
2. Choose and implement an Electronic Health Record system that spans all physician practices and services.
3. Develop and implement a comprehensive Care Coordination plan coupled with Patient Navigation.
4. Show measureable annual improvements in Quality, Patient Satisfaction and Financial Performance.

3.1.2 Two or three aims related to your participation in PRIME and how they will contribute to the overall transformation of your health system;

Two aims through the PRIME project that will contribute to the overall transformation of our health care system are to:

1. Implement a patient care model to improve the quality of care and enhance organizational performance through evidenced-based care, quality and clinical data management that will provide for better outcomes of those served.

2. Enhance community partnerships to achieve a well-coordinated, more accessible, more affordable and accountable system for delivering health care and improving population health in our community through care coordination and ongoing community engagement. This includes disease specific outreach and defined prevention and screening programs.

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

The Chronic Non-Malignant Pain Management (2.6) and Million Hearts Initiative (1.5) were selected because they address the health care needs identified in Section 2.1

and support the identified organizational goals and project aims through the utilization of care coordination, prevention and screening programs, and evidenced-based care management tools. The partnerships of medical providers, community members and regional health organizations will build a shared vision of a multidisciplinary/multimodal approach to population health management.

The CHNA and EHR data have guided evolution within TFHD to address the Triple AIM initiative to provide high-quality, coordinated care while reducing overutilization**.** This process helps determine at-risk patients who will benefit from tailored resources such as the care coordination program that includes the Chronic Disease Self-Management Program (CDSMP).

3.1.4 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);

TFHD has selected two projects: Project1.5 and Project 2.6

Together these PRIME projects will achieve system transformation integration through coordination in care delivery and population health management strategies. It is through these strategies that we have streamlined our processes and created a model of care that can be duplicated. This will assist us to improve the patient experience, quality outcomes, reduce redundancy of services, and reduce healthcare costs. The interrelated systems we have created included:

- Embedded team-based care coordination that is patient and family centered
- Improved quality through bicultural multimodal care management and safe practice guidelines.
- Improved patient compliance through bicultural self-management programs and real time home monitoring
- Common practice of prevention and screening
- Expanded health educational programming to improve population health
- Creating easy access to care through coordination and navigation thereby utilizing providers to their maximum efficiencies and effectiveness

3.1.5 A description of your vision for the delivery system at the end of the five years, including specific clinical, infrastructure and financial improvements that will support transformation.

The THFD will be transformed through the PRIME projects to show advances in clinical, population health, and fiscal accountability.

Clinical:

- Patients served will receive evidenced-based, timely clinical and support services for specific disease management.

Financial:

- Data-driven care will be provided and coordinated in the appropriate healthcare setting that will create new payment strategies.
- Cost reduction through decreased utilization of the Emergency Room through high-quality coordinated care.

Population Health Management:

- Increased patient/family engagement and improved health outcomes while reducing unnecessary and/or redundant healthcare utilization.
- Increasing reliance on community-based services including primary care to improve overall health and wellness.

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.

Our CHNA and county-level data compared to state and national statistics has led TFHD to select Million Hearts Initiative and Chronic Pain Management to address the county prevalence of *cardiovascular disease* and the prevalence of *substance use* in our community as outlined in Section 2.1.

In addition to the above health care issues, the target population endures barriers known to many in rural communities. The shortage of health care professionals (HPSA) impacts access to primary care resulting in a two to four-week wait time for new patients. Time to address the complexity of chronic diseases in the physician office is minimal. Care Coordination will increase panel size, provide individual support to improve patient adherence to the treatment plan and address prevention and screening that is often tabled due to priority of acute health issues. Defined processes for screening and referrals for Cardiovascular Disease/Stroke, Chronic Pain and Mental Health will assure follow through and improve overall patient outcomes.

Bicultural Care Coordination and the Chronic Disease Self-Management program will specifically target the Hispanic population to reduce transportation, language and cultural barriers as detailed in Section 3.5.

To address the lack of mental health professionals and high prevalence of individuals with depression in our region, TFHD will expand mental health resources including the addition of behavioral health counselors. The Chronic Pain Management Initiative integrates depression screening that will help identify patients in need. Leveraging Safe Prescribe Practices with the integration of behavioral

health will impact the drug overdose mortality rate which is nearly double the state average.

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).

TFHD organizational infrastructure aligns with PRIME specifically around developing equitable, sustainable programs and partnerships that respond to local health priorities. The publicly elected TFHD Board of Directors has demonstrated a commitment to the health and wellness of our community through the creation of the Community Benefits Subcommittee (CBS). This committee will have ultimate responsibility and oversight of these PRIME projects.

To coordinate the PRIME effort and drive transformation, TFHD will develop a PRIME Steering Committee including project leaders, executive leadership, performance improvement, community outreach staff, and data measurement and reporting staff. We will also create a dedicated PRIME Project Team to convene at least monthly during the implementation phase. Team activities will be brought to the CBS and CBS will be responsible for assuring project oversight. Project Team responsibilities will be to: 1) Review project metrics, make recommendations for improvements, monitor for successful achievement of milestones. 2) Provide input in resolving obstacles to success. 3) Seek ways to further integrate and expand on PRIME initiatives to ensure sustainability. TFHD has a project manager that will function as the PRIME Coordinator to help coordinate and manage all deliverables for these 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.

TFHD's stakeholder and beneficiary engagement will commence with the establishment of the Pain Advisory Group (PAG) and the Million Hearts Advisory Group (MHAG) committees to include: medical providers, care coordinators, pharmacists, patient advisors, and community members. This panel of expertise will address:

- Identification of target population,
- Strengths, Weaknesses, Opportunities, Threats (SWOT) Analysis and workforce gap analysis,
- Evaluation of screening tools, patient assessments and management algorithms, evidence-based Safe Prescribe Practices, and consultative/educative models of care
- Marketing and educational materials
- Policies and procedures
- Incorporation of established community partnerships into the PAG and MHAG:
    - Family Resource Centers
    - Tahoe Truckee Future Without Drug Dependence (TTFWDD)

In the last year, our Health System has partnered with the Hospital Quality Institute (HQI) to strengthen and formalize our patient and family engagement program. It involves the integration of patient and family voices into decisions about patient care, as well as health care organizational design, operations, improvement and governance. A newly formed *Patient and Family Centered Care Committee* has already on-boarded six Patient Advisors who are now an invaluable part of the fabric of the hospital culture. The next step is to recruit and on-board Patient Advisors from the primary care and ambulatory setting.

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.*

TFHD region's population is approximately 19% Hispanic. Compared to Non-Hispanics, Hispanics in the region is in poorer health, has less access to care, and are less likely to participate in preventive screenings (Example: Appendix – Graph 5).

As a result, planned efforts to ensure cultural competency in the implementation of PRIME and strategies to reduce health care disparities include:

- Care coordination services
- Developing bilingual educational materials,
- Utilization of translation services through the Language Line (real-time translation),
- Implementation of the bicultural, Stanford Model of Chronic Disease Self-Management Program (CDSMP), and
- Employment of a full-time, bilingual Health Promotora.

In addition to the above strategies, partnerships with the two local Family Resource Centers will help connect patients and families to community resources to help ensure we are effectively delivering health care services that meet the social, cultural, and

linguistic needs of patients. This includes the education necessary for a sustainable train-the-trainer program to ensure continuity of CDSMP.

These strategies will cultivate and expand current cultural competence efforts within our organization addressing the aforementioned ethnic disparities.

3.6 Sustainability. [No more than 150 words]

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

TFHD was named one of the top 100 critical access hospitals in the nation defined by measuring them across 56 different performance metrics, including quality, outcomes, patient perspective, affordability and efficiency. TFHD will leverage this experience to sustain PRIME improvements beyond the waiver by:

- Engaging Medical Providers, staff and community including patient and family advocates in the planning and implementation of the PRIME projects
- Implementing strategies to assure seamless health care services for high risk, high complex patients through care coordination and navigation
- Providing identified educational programs and training beginning with a process to identify gaps followed with learning opportunities to address these gaps
- Ensuring pooled resources and initiatives that will achieve collective impact and meet outcome measurement goals through data driven decision making
- Developing protocols, infrastructure, data reporting and review processes
- Applying continuous monitoring and evaluation to assure improved outcomes and satisfaction.

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

☒ 1.5 – Million Hearts Initiative

TFHD (DMPH) Project 1.5 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.

1. *Summarize your approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words].*

Project Rationale: TFHD selected the Million Hearts Program because it aligns with our community health initiatives around prioritizing wellness, addressing disparities and improving access to care in our community. Cardiovascular disease indicators surpass state averages and the prevalence of adult obesity is on par or exceeds the California average in 3 counties. The prevalence of hypertension is well above the Healthy People 2020 goal of 26.9%. To reach this goal we will have to reduce the prevalence of hypertension by 59% from 45.36% to 26.9%. Integrating the screening algorithms of the Million Hearts initiative into primary care will increase identification of at-risk individuals and improve referral and follow-up to reduce the risk of CVD and Stroke.

Project Design and Implementation Approach: Our primary focus is to work with our local health clinics and community to create a culture of health by expanding care coordination, streamlining workflow process and expanding outreach and educational programs.

- **Care Coordination***:* Expand care coordination bicultural support and education to improve behavior change interventions, patient adherence to treatment recommendations, access to care, and the patient experience. (DY12)

- **Clinical Workflows***:* Streamline the workflow processes to help identify, educate, timely follow-up, treat and refer high risk patients in the primary care setting by demonstrating the capacity of the EHR to support this plan,

designating this model for future expansion into other health conditions, increase evidenced-based preventative screenings and care. (DY12)

- **Health Education***:* Develop and expand health education programs and community resources to reduce barriers to participation, improve patient outcomes through technology enabled home monitoring. (DY12)

- **Chronic Disease Prevention**: Create a culture of health by implementing wellness policies and environmental change such as smoke free environments, and access to healthy foods to make the "healthy choice the easy choice". (DY12)

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

Target Population: The target population for this project is adults 18 years and older enrolled in Medi-Cal. By adopting the Million Hearts initiative, our community will become more aligned with the US Preventative task force recommendations and Healthy 2020 goals.

Vision for Care Delivery: Million Hearts will enable our health clinics to use best practice management guidelines and care coordination to improve communication and outcomes. The TFHD Care Coordination Program and Chronic Disease Self-Management Program will further be developed to assist patients in navigating through their disease process. These programs are geared towards meeting patient's individualized needs and support the patient's central role in managing their illness, improving patient and family satisfaction, and reducing fragmentation in care. Through the use of evidenced-based communication strategies such as, health coaching and a standardized referral system embedded in the EHR, patients will experience increased self confidence in making appropriate healthcare choices structured within the care coordination program. By integrating seamless bicultural screening and prevention processes, primary access to health interventions is more attainable thus improving overall population health.

Increased screenings, education, outreach, implementation of wellness policies, and environmental changes throughout our community will help establish a culture of health where the "healthy choice is the easy choice." When wellness is part of our community culture, there will be improved access to healthy foods and tobacco free environments which support a healthier lifestyle.

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

Check, if applicable	Description of Core Components
Applicable	**1.5.1** 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	**1.5.2** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to the US Preventive Services Task Force (USPSTF) A and B Recommendations.
Applicable	**1.5.3** Improve access to quality care and decrease disparities in the delivery of preventive services.
Applicable	**1.5.4** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
Applicable	**1.5.5** 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.
Applicable	**1.5.6** 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	**1.5.7** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. • Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts.
Applicable	**1.5.8** Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.

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:		**1**

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

☒ 2.6 – Chronic Non-Malignant Pain Management

TFHD (DMPH) Project 2.6 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.

Summarize your approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words]

Project Rationale: Community need drove our selection of this project. TFHD's 2014 CHNA revealed 25.1% of respondents experience lingering or chronic injury that causes substantial pain or limits daily activities (Appendix- Graph 6). In addition, our community experienced a 50% increase of household abused drugs from 3.3% in 2011 to 6.1% in 2014 (Appendix- Graph 7). Lastly, TFHD EHR data shows14.4% of chronic pain patients had mental health related co-morbidities (2015).

Project Design and Implementation Approach: Evidenced-based practice guidelines, such as the *CDC Guideline for Prescribing Opioids for Chronic Pain* (2016), are driving design of our Chronic Pain Management Program. TFHD's participation in Placer & Nevada Opioid Safety Coalition also ensures project design is progressive and using the most up-to-date best practices.

- **Patient Identification***:* Patients at risk will be identified by screening patients seen in the ED, Hospital or clinics. Outreach to community providers will invite patient referrals for those at risk. (DY12)

- **Pain Assessment and Management Algorithms***: The Pain Advisory Group (PAG)* will review clinical workflow in the ED and health clinics to develop common clinical pathways using evidenced based guidelines. (DY12)

- **Education and Training:** PAG will assess the level of education needed for the providers in the health clinics and ED regarding pain assessment and management guidelines, screening tools, patient self-management and referral processes and resources including safe prescribe guidelines. (DY12)

- **Referral Processes***:* TFHD will identify community-based mental health and substance abuse resources and develop and maintain a contact list available through the TFHD intranet. Identified gaps in available services will result in strategies to address those gaps. (DY12)

- **Monitoring and Evaluation Processes**: The model for continuous improvement is the Define, Measure, Analyze, Improve, and Control (DMAIC) model that refers to a data-driven quality strategy. (DY12)

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

Target Population: The target population for this project is Medi-Cal beneficiaries who have a diagnosis of moderate to severe pain lasting >90 days. Depression screening tool, PHQ-2, will be used for all adult patients and pediatric patients ≥12. Screening, Brief Intervention and Referral to Treatment (SBIRT) will be used for adult patients ≥18 years of age. Age specific screening tools such as CRAFFT(Car, Relax, Alone, Forget, Family, Friends, Trouble) will be used for children ages 12 to 17 for alcohol and other drug use disorders.

Vision for Care Delivery: Our vision is that the PRIME project will improve primary care providers' and care teams' ability to identify, and manage age-specific, chronic non-malignant pain using a function-based, multimodal approach. Project patient information and adherence to confidentiality will be respected amongst all populations served.

Expansion of the TFHD Care Coordination Program will include chronic pain management into the existing bicultural Chronic Disease Self-Management Program. Patients will be navigated through their disease process to meet their individualized needs that will emphasize the patient's central role in managing their illness, and as a result, will achieve better health outcomes. Individualized care plans will optimize care, reduce readmissions, reduce emergency department visits, reduce adverse drug events, and provide better control of pain management.

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

Check, if applicable	Description of Core Components
Applicable	**2.6.1** Develop an enterprise-wide chronic non-malignant pain management strategy.
Applicable	**2.6.2** Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**2.6.3** Implement or adapt a state or nationally recognized methodology for the assessment and management of chronic pain.

Check, if applicable	Description of Core Components
Applicable	**2.6.4** Implement protocols for primary care management of patients with chronic pain including: • A standard standardized Pain Care Agreement. • Standard work and policies to support safe prescribing practices. • Comprehensive pain history including psycho/social evaluation, functional evaluations, care plan, pain medication risk/benefit informed consents, ongoing monitoring of plan/outcomes (e.g., use of standardized monitoring template for follow-up visits for CNP), aberrant behavior screening and management protocols. • Guidelines regarding maximum acceptable dosing.
Applicable	**2.6.5** Provide culturally, linguistically and literacy level-appropriate patient education on the pathology of chronic pain, rationale for rehabilitation and expected goals of treatment.
Applicable	**2.6.6** Coordinate a chronic pain care team that minimally consists of a physician champion and medical support staff. Suggestions for care clinicians from other disciplines include occupational and physical therapy, behavioral health, pharmacy, substance use disorder specialists, neurology, occupational medicine, anesthesiology/pain management, home care, social work, and physical medicine and rehabilitation.
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 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.
Applicable	**2.6.11** Develop a process for scheduling pain focused follow-up patient visits to ensure that patients receive refills in a timely manner while also receiving recommended monitoring for signs of diversion or misuse.
Applicable	**2.6.12** Develop staff and clinician training regarding the organization's process for managing patients with chronic non-malignant pain.

Check, if applicable	Description of Core Components
Applicable	**2.6.13** Train providers to identify signs of prescription opioid use disorders and provide treatment options for patients diagnosed with opioid use disorders, including suboxone treatment, referral to methadone maintenance, referral to inpatient and outpatient substance use disorder treatment facilities, and referral to needle exchanges.
Applicable	**2.6.14** Develop and implement protocols for prescribing naloxone to patients receiving opioids for chronic pain.
Applicable	**2.6.15** Identify standardized multidimensional pain assessment, functional assessment, psychological assessment, and opioid assessment tools that meet the needs of the care clinicians and are appropriate for the patient populations.
Applicable	**2.6.16** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. Timely, relevant and actionable data is used to support patient.

Please complete the summary chart:

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

Section 5: Project Metrics and Reporting Requirements

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

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

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

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

Section 6: Data Integrity

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

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

Section 7: Learning Collaborative Participation

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

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

Section 8: Program Incentive Payment Amount

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

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

- DY 11 $ 1,700,000
- DY 12 $ 1,700,000
- DY 13 $ 1,700,000
- DY 14 $ 1,530,000
- DY 15 $ 1,300,500

Total 5-year prime plan incentive amount: $ 7,930,500

Section 9: Health Plan Contract (DPHs Only)

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

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

Section 10: Certification

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

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

Appendix- Infrastructure Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start/End Date
1.	Integrate Care Coordination	1. Develop Referral Process for Care Coordination 2. Educate Medical Providers and staff on care coordination referral process 3. Implement care coordination referral process	1.5, 2.6	January1, 2016- June 30, 2016
2.	Implement system for continual performance feedback and rapid cycle improvement	1. Develop process to provide feedback to care teams around preventive service benchmarks and QI efforts 2. Development of patient and staff surveys for targeted feedback of service design and implementation 3. Design workflows and documentation to reinforce patient engagement in plans of care	1.5, 2.6	January 1, 2016- December 31, 2016
3.	Develop system for data collection to establish metric reporting, communica-ting on tools	1. Conduct gap analysis to understand needs and limitations of current and future systems for tracking necessary data and required metrics. Review gaps in EHR (Electronic Health Record) and electronic communication. 2. Create system to track and report patients as well as other required metrics. 3. Develop and implement an electronic communication tools needed for staff. 4. Train/educate appropriate staff on how to use system to track necessary data and required metrics and on electronic communication tools and protocols. a. Implement system to track necessary data and required metrics.	1.5, 2.6	January 1, 2016- December 31, 2016
4.	Establish key stakeholders for the Million Hearts Advisory	1. Recruit Medical Provider champion, psychologist, pharmacist, clinic care coordinator, practice champion, health and wellness educator, community collaborative partners, IT analyst, cardiac rehab, marketing and patient/family advisor	1.5	January 1, 2016- June 30, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start/End Date
	Group (MHAG)	2. Develop education materials for Million Hearts Initiative 3. Educate Key Stakeholders re: Million Hearts Initiative 4. Attain consensus to adopt preventative screening assessments and algorithms a. Patient referral process b. Policy and environmental interventions such as healthy vending machine choices. 5. Establish timeline and set meeting times a. Key stakeholders set outcome objectives using Million Hearts guidelines		
5.	Determine staff needed to be hired	1. Conduct a workforce gap analysis to determine staff that need to be hired, redeployed, retrained to implement new program/ intervention 2. Develop job description with core responsibilities 3. Recruit/retain 1 care coordinator 4. Recruit/retain 1 provider champion 5. Recruit/retain program manager 6. Interview candidates 7. Hire staff by 5/30/16 8. Develop orientation and training plan 9. Train new and existing staff that includes health promotora, data analyst, IT personnel, community educator, and practice manager	1.5	January 1, 2016- June 30, 2016
6.	Develop and Implement the data registry	1. Identify and develop cross-functional team to create and implement registry 2. Assess and determine hospital's current and estimate future capacity and resources needed to operate and sustain a data registry 3. Develop data registry schema to include: a. Identification of treated or non-treated hypertension confirmed by chart review	1.5	January 1, 2016- December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start/End Date
		i. Identification of hypertensive criteria to include: 1. Individuals ages 18 to 59 whose BP was <140/90 mm Hg 2. Individuals ages 60 to 85 with a diagnosis of diabetes whose BP was <140/90 mm Hg 3. Individuals ages 60 to 85 without a diagnosis of diabetes whose BP was <150/90 mm Hg ii. Identification of most recent BP post diagnosis reading during the measurement period iii. Identification of Diabetic patients with hypertension include prescriptions iv. Process to include exclusion criteria b. Systematic process to identify patients 18> discharged alive for ICD10 codes: Acute Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG), Percutaneous Coronary Interventions (PCI), Ischemic Vascular Disease (IVD) with documentation of aspirin/antithrombotic (12 months prior and during) c. Create a process to flag: i. Aspirin or another anti-thrombotic		

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start/End Date
		d. Identification of patients 18> screened for tobacco use and received cessation counseling intervention include exclusion criteria using algorithm e. Develop process to flag necessary data from the EHR to initiate preventive services referrals (e.g. smoking cessation, Million Hearts, Chronic Disease Self-Management etc.), screenings, and follow up interventions f. Create a process for preventive care and screening for high blood pressure for individuals 18> using algorithm i. Using defined classifications: Normal, Pre- Hypertensive, First Hypertensive, and Second Hypertensive Readings. g. Using recommended lifestyle recommendations for initial BP follow-up such as Dietary Sodium Restriction h. Using recommended lifestyle recommendations for second BP follow-up such as pharmacologic therapy i. Develop process for follow-up interventions i. Include exclusion criteria 4. Develop a plan to build and implement registry 5. Build registry 6. Train staff on how to use registry 7. Design workflows and documentation to encourage usage of registry 8. Implement registry at all clinics		

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start/End Date
7.	Develop Care Processes to align with Million Hearts Initiatives	1. MAHG and Community Benefits Committee approve protocols and/or algorithms based on CDC Million Hearts Initiative and PRIME core measures 2. Develop education materials on care process for Million Hearts initiative 3. Identify and educate Health Clinic Staff on protocols re: care process algorithm using Million Hearts Initiative 4. Develop core competencies for standardization for BP measurement 5. Educate Medical Providers in Health clinics re: screening tool for use of Aspirin or other antithrombotic 6. Educate Medical Providers on use of algorithm treatment choices 7. Educate providers on Aspirin therapy or other antithrombotic within the Medi-Cal formulary to improve compliance 8. Educate Medical Providers and clinic staff re: assessment and counseling for tobacco use 9. Pilot care processes and make changes where necessary 10. Implement care process algorithms into the EHR 11. Develop process flow for referrals into the EHR 12. Educate providers on process flow for referral 13. Pilot referral process 14. Implement referral process	1.5	January 1, 2016- December 31, 2016
8.	Target and Expand Community Health Education Programming included in the referral algorithm	1. Expand smoking cessation interventions to include best practices (i.e.: Kick Nicotine program, Pharmacist integration Quit Line, Email/social media support, Spanish language interventions) 2. Track program referrals and actual enrollment into identified program	1.5	January 1, 2016 – December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start/End Date
		3. Develop BP tracking and follow-up intervention to include best practices i.e.: “Know Your Numbers” wallet card. 4. Create and distribute a single BP Control brochure in the community for consistent messaging and call to action. 5. Streamline referral process and referrals to following programs: a. Weigh to Go (TFHD existing Wellness Program) b. Nutrition group and individual Counseling (DASH Diet, Cholesterol management) c. Medically supervised exercise (TFHD existing Silver Steps program) d. Heart Healthy Community Nutrition Classes (TFHD existing group education classes) e. Track program referrals and actual enrollment into identified program 6. Collaborate and educate community partners such as Family Resource Centers on Million Hearts Initiatives to improve access to care. 7. Create education information content a. Incorporate CVD risk reduction into TFHD “Wellness at Work” program b. Track through newsletter content c. Incorporate CVD risk reduction into B-FIT program (TFHD school based wellness program) 8. Incorporate BP screenings into community events such as Health Fairs 9. Incorporate BP control theme in Community Walking Challenges		

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start/End Date
9.	Implement Policy and Environmental Change	1. Develop a policy to increase smoke-free environments 2. Share developed TFHD policy with at least two community employers such as Public Utility District 3. Increase access to healthy choices in two hospital vending machines (food and beverages). a. Change selection to offer at least 50% healthy choices b. Increase percent of items with lower sodium content by 5% c. Set upper level of sodium content per item (for example no more that than 360mg of sodium) d. Eliminate items with trans fat	1.5	January 1, 2016- June 30, 2016
10.	Establish Key Stakeholders for the Pain Advisory Group	1. Recruit Medical Provider champion, primary care and ED medical staff, pharmacy, anesthesiologist (pain clinic), social services, rehab services, business office, patient advisor, community partner: Tahoe Truckee Future Without Drug Dependence (TTFWDD) a. Identify Patient Advisor(s) experiencing chronic pain b. On-board Patient Advisor(s) through the Family Centered Care Committee 2. Pain Advisory Group is selected and schedule established 3. Establish timeline and set meeting times 4. Key stakeholders set outcome objectives for chronic pain management group	2.6	January 1, 2016- June 30, 2016
11.	Develop and Implement the Data Archive	1. Develop Data archive schema to include: ICD10 codes: R52.1 or R52.2, Z79.891,G89.4) 2. Assess and determine hospital's current and estimate future capacity and	2.6	January 1, 2016- December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start/End Date
		resources needed to operate and sustain a data archive 3. Develop data points to be monitored a. Positive depression screening ie: (PHQ2) with documented follow-through to include referral/suicide risk assessment and/or pharmacy intervention b. Care assessment c. Medication refill standing orders d. Annual PDMP checks (checkbox in EHR) for pts on opioids to include: (Codeine, Fentanyl, Hydrocodone, Hydromorphone, Methadone, Morphine, Oxycodone, Oxymorphone, Tramadol) e. Referrals for non-opioid pain management and/or multimodal therapy f. Patients age 12 to 17 screened using CRAFFT encounter g. Patients age 18 and older screened using SBIRT h. Annual Urine toxicology test documented in the EHR i. Medication Agreement documented in EHR 9. Develop consistent process for medical record review to help determine cause of depression-exclude bipolar. 10. Develop plan to build and implement archive 11. Design workflows and documentation to encourage usage of archive 12. Train staff on how to use archive 13. Go live with archive		

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start/End Date
12.	Pain Advisory Group meet with TFHD Program Analyst to conduct a SWOT analysis	1. Project Manager and Program Management Analyst guide key stakeholders in SWOT for new chronic pain management program 2. SWOT completed and used to guide further program development	2.6	January 1, 2016- June 30, 2016
13.	Pain Advisory Group adopts an evidence-based guideline for a bio-psychosocial model of care	1. Identify and modify existing tools such as: ICSI (Institute for Clinical Systems Improvement) assessment to include: Biological, Functional and Psychosocial assessment 2. Identify and modify existing chronic pain management algorithm such as ICSI sixth edition (2013) 3. Identify and modify existing protocols for using assessment tools 4. Identify and modify existing protocols for using pain management algorithm 5. Chronic Pain Advisory Group consensus to adopt tools 6. Develop process flow for tools 7. Train staff on tools and process 8. Pilot tools, make changes where necessary 9. Implement tools	2.6	January 1, 2016- December 31, 2016
14.	Implement Model of Care Assessment and Management Guidelines Algorithm tools	1. Incorporate Assessment & Pain Management Guidelines or algorithm tools into the EHR 2. Develop process flows for tools 3. Develop patient follow-up process 4. Train clinicians on tools and processes 5. Pilot tools and processes, make changes where necessary 6. Implement tools and processes Evaluate utilization of assessment tools	2.6	January 1, 2016- December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start/End Date
15.	Determine staff needed to be hired	1. Conduct a workforce gap analysis to determine staff that need to be hired, redeployed, retrained to implement new program/ intervention 2. Develop job description with core responsibilities 3. Recruit/retain candidates 4. Interview candidates 5. Hire staff – Program Manager, Care Coordinator, LMFT or MSW, Data Analyst, Provider Champion 6. Develop orientation and training plan to include for a. CDSMP Leader Training Program b. Shadow existing Care Coordinator c. SBIRT online modules (evidenced –based program) d. Unique tool (CRAFFT) specific to adolescent (12 -17) screening risk for alcohol and drug misuse e. Review Health Care Guideline Assessment and Management of Chronic Pain by ICSI and CDC(Centers for Disease Control and Prevention) Guideline for Prescribing Opioids for Chronic Pain-2016 f. Codes for SBIRT and CRAFFT billing full screen encounters 10. Develop Orientation plan for existing staff: 11. Train new and existing staff that includes health promotora, data analyst, IT personnel, community educator, and practice manager	2.6	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start/End Date
16.	Incorporate Multimodal Therapies into the Chronic Pain Management Algorithm	1. Research community programs and availability of resources 2. Develop resource catalogue for Care Coordination to include multi-modal therapies 3. Develop referral process for multi-modal therapies using the EHR 4. Train staff on how to access resource catalogue 5. Train staff on referral process for multi-modal therapies 6. Implement referral process for multi-modal therapies	2.6	January1, 2016- December 31, 2016
17.	Adopt evidence-based Models or Nationally Recognized Guidelines to ensure early identification of mental/behavioral health co-morbidities (i.e. depression)	Evaluate CMS and National Quality Forum guidelines in relation to mental/behavioral health Develop new or select existing standardized screening tool/Patient Health Questionnaire (PHQ) Develop Depression Screening Policy Review and educate Medical Providers location and use of screening tool Implement screening tool		January1, 2016- June 30, 2016
18.	Develop Chronic Pain Management Policies and Procedures	1. Develop referral process for patients to be enrolled into the chronic pain management program 2. Identify and modify existing Safe Prescribe policy to include Medication Agreement and Urine toxicology protocol 3. Develop a policy for annual SBIRT and CRAFFT screening 4. Align policies and procedures through TFHD approval process		January1, 2016- December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start/End Date
		5. Incorporate policies and procedures into the Multi-Specialty Clinic policy and procedures 6. Train Health Clinic Staff on policies		
19.	Develop a Behavioral Health Resource Process for Positive Depression Screening	1. Identify and implement existing distress screening tool 2. Develop a follow through process to determine next steps and treatment interventions based on the patients self-determined scores 3. Identify and implement existing Behavioral Health resource process for positive depression screening 4. Train staff on processes Implement processes		January1, 2016-December 31, 2016
20.	Develop Educative/Consultative Model of Care for Medical Providers	1. Research Chronic Pain programs regarding ongoing participatory education and consultation 2. Identify aneducative/consultative model of care for Medical Providers-Project Echo 3. Develop workflow processes 4. Develop training/education materials 5. Pilot new program and make changes where necessary 6. Implement program throughout Primary Care Clinics.		January1, 2016- June 30, 2016
21.	Implement Safe Prescribe Practices (CMA)California Medical Association	1. Chronic Pain Advisory Group will research (CMA) approved Safe Prescribe Practices and Center for Disease Control (CDC) opioid guidelines for opioid treatment 2. Research evidenced based Medication Agreements 3. Select appropriate Medication Agreement to align with CMA guidelines 4. Create Safe Prescribe educational materials for both ED and primary care providers		January1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start/End Date
		5. Educate Medical Providers Safe Prescribe practices through e-mail messaging, CME presentation and Medical Staff presentation to include: Use of Medication Agreement, Urine toxicology protocol, use of PDMP(CURES) using the CDC opioid guidelines 6. Develop Urine Toxicology protocol based on the adopted Safe Prescribe Practice guidelines 7. Develop a plan for the use of Naloxone protocols based on CMA (California Medical Association) recommendations and existing best practices. 8. Pilot Safe Prescribe Practices in one clinic/ED, make changes where necessary Implement Safe Prescribe Practices within TFHD Health Clinics and ED		
22.	Patient satisfaction questionnaire incorporated into existing Press-Ganey related to chronic pain management	1. Identify and modify existing out patient satisfaction questionnaire specific to chronic pain management patient 2. Implement through patient survey management vendor 3. Analyze Results from patient Survey 4. Make changes to chronic pain management program based on survey results.		January1, 2016-December 31, 2016

Appendix

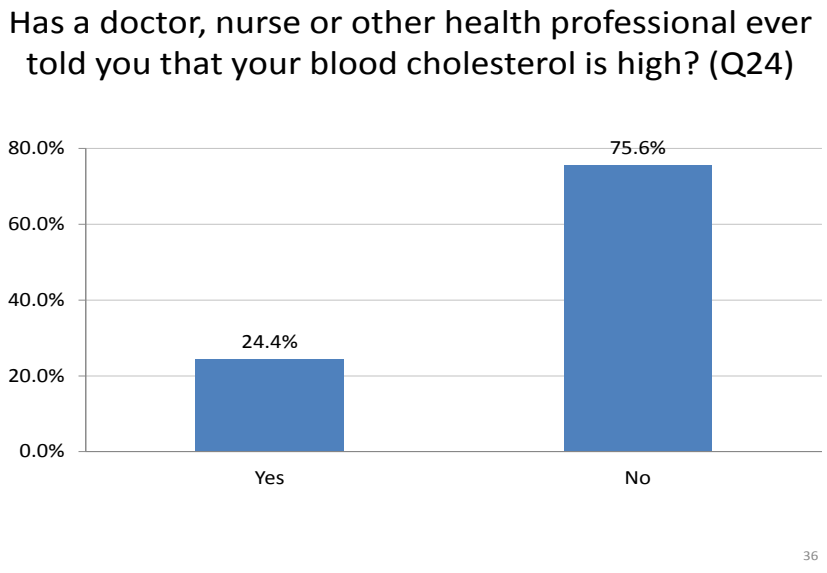
Table 1: California County Health Factors, 2015* The *County Health Rankings* is a way to help us focus our efforts on factors that can lead to the biggest gains in health.

	Percentage of adults whom are current smokers	Adult Obesity	Percentage of adults reporting heavy alcohol use	Percentage of driving deaths with alcohol involvement	Mental Health Providers
California	**13%**	**23%**	**17%**	**31%**	**376:1**
El Dorado County	**14%**	21%	**21%**	**44%**	**414:1**
Nevada County	**14%**	18%	**17%**	**38%**	215:1
Placer County	8%	**23%**	16%	**33%**	**455:1**
Plumas County	**14%**	**25%**	**18%**	**33%**	**401:1**
Sierra County	NA	**23%**	NA	**31%**	**609:1**

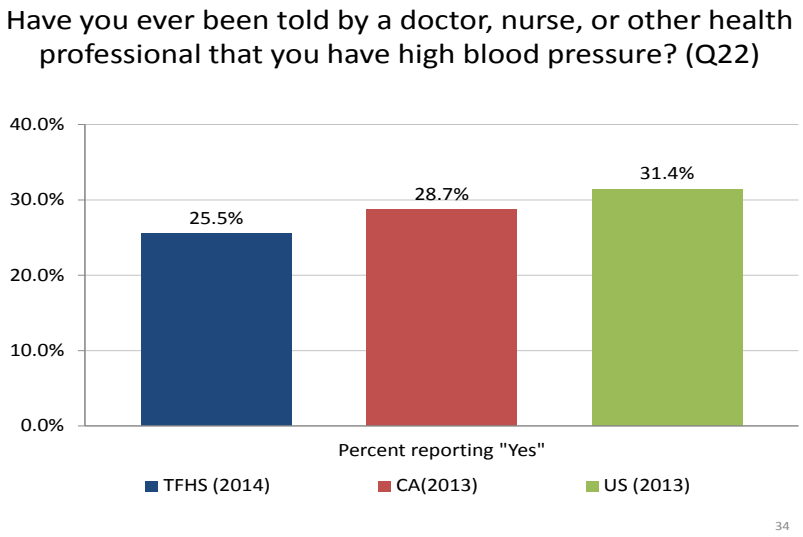
* http://www.countyhealthrankings.org/app/#!/california/2015/overview

Graphs 1-7: TFHD Community Health Needs Assessment (CHNA) BRFSS Survey (2014) Results

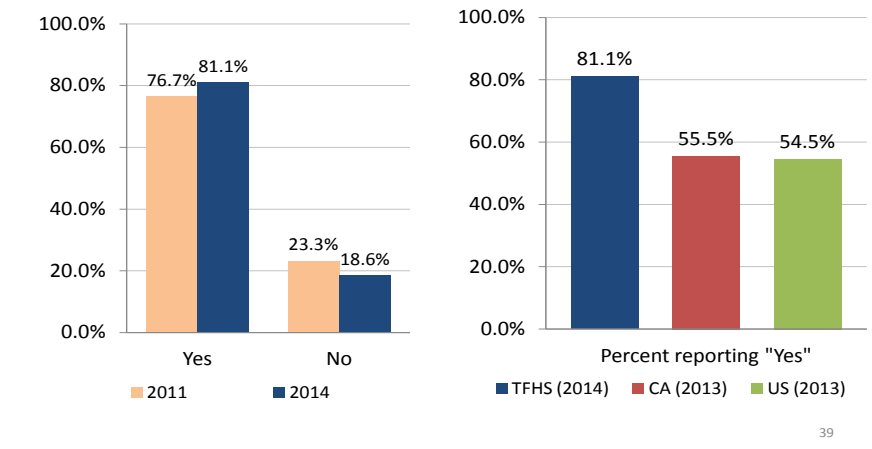
Graph 1: Cholesterol



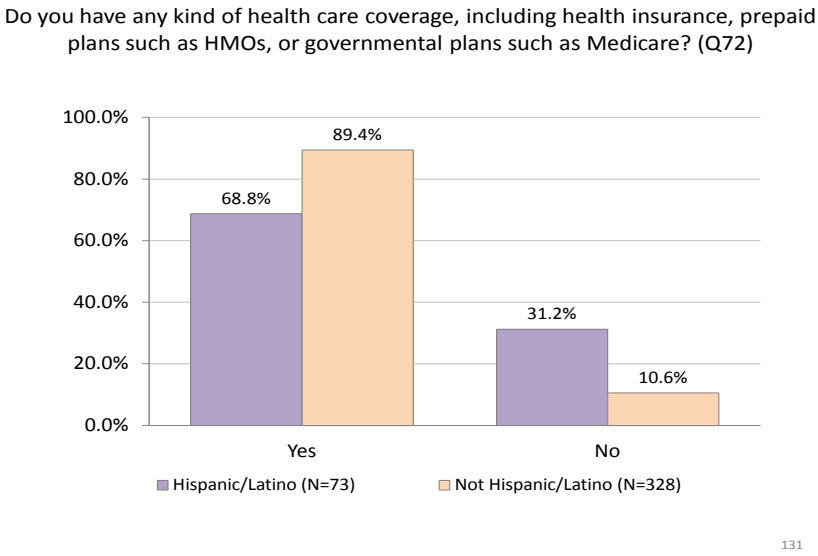
Graph 2: Hypertension



Graph 3: Alcohol Use



Graph 4: Health Care Coverage: Hispanic vs. Non-Hispanic



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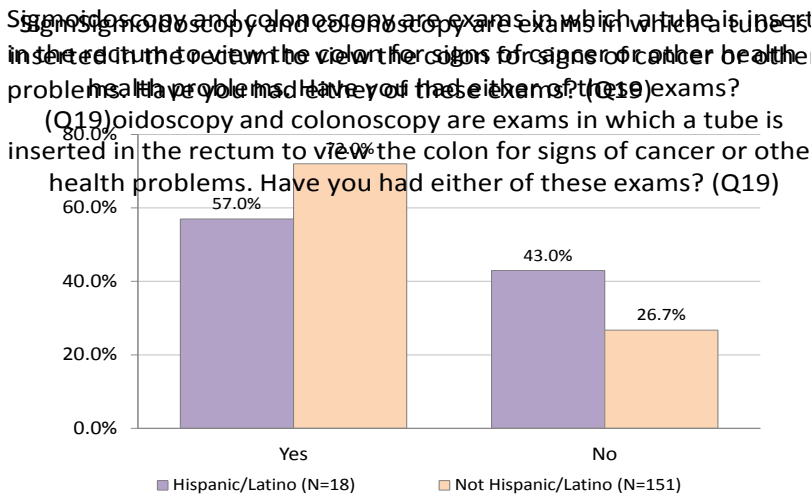
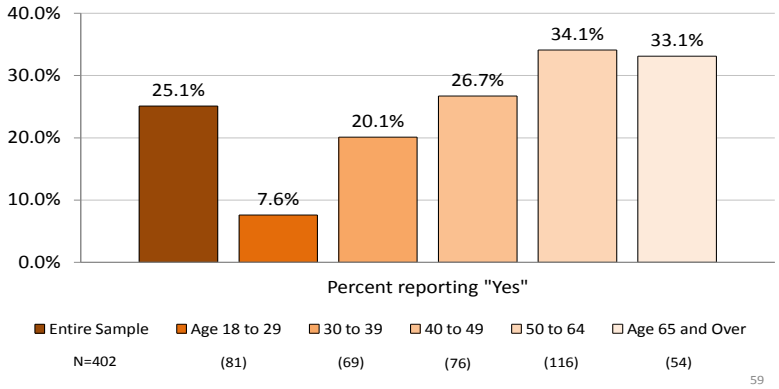
Graph 5: Preventive Screening Practices



31

Graph 6: Chronic Injury and Pain

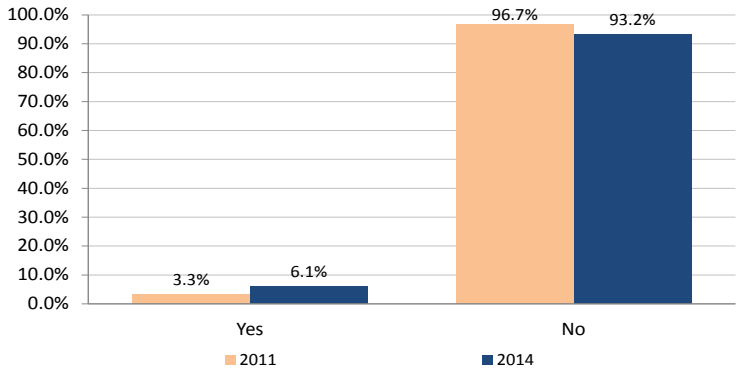
Do you have a lingering or chronic injury or ailment to a major joint or your back that gives you substantial pain or limits your daily activities or sports you enjoy? (Q42)



59

Graph 7: Drug Abuse

Have you or someone in your household abused drugs, including prescription medicines, in the past year? (Q38)



2014 TFHS Community Health Needs Assessment

Table 2: CMS Chronic Disease Beneficiaries Prevalence, 2014*

	Depression	Hypertension	Hyperlipidemia
California Prevalence	**13.9%**	**50.1%**	**41.7%**
El Dorado County	**14.9%**	46.8%	**44.4%**
Nevada County	**14.6%**	44.2%	41.6%
Placer County	**15.1%**	47.0%	**42.1%**
Plumas County	**15.6%**	42.7%	36.0%
Sierra County	**17.0%**	46.1%	39.0%
Healthy People 2020 Goals	26.9%		13.5%

* https://ccw.maps.arcgis.com/apps/MapSeries/index.html?appid=c125954f1a1e4582916d8a666f2bf58

Table 3: Drug Overdose Deaths – modeled (California Health Ranking 2016)

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County	Range Drug Overdose Mortality Rate per 100,000 population
El Dorado	>20
Nevada	>20
Placer	12.0-14.0
Plumas	>20
Sierra	>20
California	11.1

[i] CDC Health Disparities and Inequalities Report – U.S. 2013. Updated November 2013.

[ii] U.S. Census 2010 - 2014

[iii] American Fact Finder 2009-2013

[iv] California Department of Education