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

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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

Plumas District Hospital

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.

Plumas District Hospital (PDH) is located in Quincy, the county seat of Plumas County, and serves the neighboring communities of Greenville, Taylorsville, Meadow Valley, and Crescent Mills. The needs and disparities of our community are discussed below.

Physical Health:
Over the last several years, the number of prescribed narcotics, office visits and LCSW visits related to chronic nonmalignant pain management have increased in our community. We have been proactive in referrals to pain specialty, physical therapy, counseling and other adjunctive forms of pain management. However, we suspect a high non-compliance rate for all alternative therapies.

Common conditions associated with chronic pain include osteoarthritis, migraines, fibromyalgia, and chronic neck and low back pain. It is likely that underlying mental health and substance abuse issues are present in a significant percentage of the patients on chronic opioids. Anecdotally, we suspect there is a correlation between workers compensation cases and chronic pain, which may contribute to the County's high unemployment rate (16.7%).

Between July 1, 2015 and March 31, 2016, PDH has referred 120 to a pain management specialist 25 miles away.

Behavioral Health:
Plumas County had the highest incidence in California of opioid-related deaths per capita (24.2/100,000 events) from 2009-2013. Non-fatal opioid related emergency visits in Plumas County were 63/100,000 in 2013. ED visits due to alcohol- or drug-related causes are higher than statewide as well: 620.9/100,000 and 335.9/100,000 respectively. Hospitalizations due to alcohol- or drug- related causes are higher than the state average: 193.2/100,000 as compared to 145.8/100,000 statewide. Suicide rates are also higher: 18.4/100,000, as compared to 9.4/100,000 statewide.

The Department of Health Care Services (DHCS) estimates that 12.3% of Plumas county residents have a broadly defined need for mental health services, lower than the statewide average of 15.85%. We suspect that the lower percentage seen in Plumas County is due to a lack of mental health services availability.

Health Disparities:
Plumas County's overall percentage of population living below the 2015 Federal Poverty Level is 15.9%. Plumas County residents have poor health outcomes and experience a fragmented health care continuum. Before Affordable Care Act implementation, 19.1% of residents over 18 had no insurance. According to DHCS, Plumas County Medi-Cal enrollment has increased by 54% since Managed Care expansion started in 2014.

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.

PDH serves the communities of Quincy, Meadow Valley, Greenville, Taylorsville, and Crescent Mills in central Plumas County, which is home to 8,972 Californians (55% of the county's total population). Plumas County is remote, mountainous, sparsely populated, with a population density is 7.8 persons/square mile, and is located 150 miles northeast of Sacramento.

Race/Ethnicity and Language:
The population of Plumas County is 89.6% Caucasian, 5.7% Hispanic/Latino, 2.8% Native American, 0.7% Black, 1% Asian, .08% Hawaiian/ Pacific Islander, 1.2% identified as members of other ethnicities, and 3.9% multiracial. Although the county is ethnically less diverse than the state as a whole, the Latino population is growing and nearly doubled over the past 20 years. While English is the primary language, 9.6% of the population reports speaking a language other than English at home.

Income:
The average per capita income in Plumas County is $29,167 and the median family income is $48,032. These income levels are roughly equal to and more than 30 percent below the average for California, respectively. Additionally, 15.9% of the county population is living below the poverty line, with 45% of this population living in the communities served by PDH.

Age:
The population is older than the state overall, with an average age of 51.7 years (compared to 35.6 statewide). The age breakdown is as follows:

- Under 18 years (11%)
- 19-64 years (80%)
- 65 and over years (9%)

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.

PDH is a district hospital established in 1955. It is comprised of a critical access hospital (CAH) and rural health clinic (RHC) located in Quincy, California. A second RHC is located 22 miles away, in Greenville, California.

The hospital is licensed for 25 beds and provides the community with inpatient and outpatient services, including surgery, endoscopy, emergency room, ambulance and a robust telemedicine program, including tele-stroke, pediatric critical care in the ED, and a specific unit dedicated to neonatology. PDH is the only hospital in Plumas County providing obstetrical services.

PDH's RHCs provide services to an average of 2,400 patients per month. The clinics feature six family practitioners, four mid-level providers, and visiting physicians in the following specialties: cardiology, gynecology, neurology, ophthalmology, orthopedics, otolaryngology, podiatry, urology, and a spine specialist. On site, we have a certified diabetes educator and behavioral counseling provided by an LCSW. Multiple subspecialty consultations are provided via telemedicine, including tele-psychiatry and pain medicine. PDH also provides Medi-Cal dental services.

PDH was named in the Top 100 CAHs in the country by iVantage Analytics in 2014 and 2015, and was the only hospital out of 34 CAHs in California to receive this award. PDH has met all of the UC Davis criteria to be designated a Rural Center of Excellence, and is consistently involved in the training of medical students and resident physicians.

Payer mix:

- HMO/PPO: 20%
- Commercial: 7%
- Worker's Comp: 1%
- Medicare: 43%
- Medi-Cal: 7%
- Mgd Care M-Cal: 21%
- Other: 1%

- CMSP: -1%
- Charity: 0%
- Self-Pay: 3%

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.

PDH has attested successfully for Meaningful Use, indicating that we have a workforce and system flexible to respond to changing federal reporting requirements. We currently have two EHRs, one for our hospital and another for our RHCs.

Data Collection:
At this point, except for claims data submission, our level of infrastructure is none to minimal. We primarily have a manual data collection process with limited Clinical Quality Measures (CQM) data available from the EHRs.

Reporting and Monitoring:
Currently, we do not have electronic tracking indicators, but are investigating quality management software to track performance. We plan to bring on qualified staff to manage performance data and new system build out for EHR reporting. Additionally, we have restructured our Quality Oversight Committee to address increasing reporting requirements and reduce duplicative or overlapping manual data collection efforts.

Barriers and Challenges:
Meaningful Use continues to be a primary driver in the development of the EHR software and could present a significant barrier if requests for system modifications are assigned a lower priority. PDH is persistently limited in staffing resources and current staff has numerous responsibilities.

PDH proposes to limit or eliminate these barriers by placing PRIME as a top priority project, assigning and/or hiring resources as needed to accomplish its goals. The Quality Oversight Committee will oversee all reporting measures, program objective compliance and data evaluation, whereupon findings will be reported to relevant departments for feedback and process improvement both in real-time and regularly scheduled meetings to ensure data driven decisions.

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.*

PDH's overarching goal is to improve the health and wellness of our patients by providing personalized, high quality care. As a small critical access hospital, we strive to use resources wisely, and actively participate in programs such as PRIME and MBQIP, as we move toward adapting population health management and alternative payment models.

Through PRIME, PDH intends to implement a more effective approach to manage chronic pain for our patients. We will utilize an evidence based, patient centered, standardized plan of care. PDH intends to decrease adverse outcomes associated with inappropriate uses of opioids and other addictive medications.

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.*

We have four specific project aims for PDH's PRIME participation: 1) to reduce total opioid prescribing for patients in the 18 years and older; 2) to reduce prescription opioid related overdose and deaths, 3) to reduce ED visits related to opioid use or abuse, and 4) to increase effective pain management using multi-modal therapies.

Utilizing evidence based medicine, together with nationally recognized methodologies and best practices we intend to develop an organization-wide chronic nonmalignant pain management strategy. Patients will be engaged though educational literature, postings, standard protocols, and most importantly through a trusting patient-provider relationship. A "Pain Management Agreement" will hold patients accountable. This agreement will allow for both routine and random urine testing, pill counting, and clear consequences regarding aberrant behaviors, substance abuse, diversion practices and general non-compliance.

PDH will evaluate provider practices and provide feedback and education. Data collection including ICD-10 codes unique to chronic pain patients on opioids will be used to develop a registry for pain assessments, contracts, refill policies, and protocols for urine toxicology.

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;*

PDH selected the chronic nonmalignant pain management project (Project 4.2.6). This project directly aligns with our overarching goals as outlined above and will allow us to build and implement a comprehensive pain management program to reduce opioid overuse and increase effective pain management strategies.

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

PDH has selected Project 4.2.6

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.*

At project conclusion, chronic pain patients served by PDH will receive effective pain management, as evidenced by improved functionality and perceived quality of life. We will have the infrastructure and staff to identify physical and psychosocial needs of this population. We anticipate an overall reduction in

high narcotic dosing regimens, and opioid-related emergency visits and hospitalizations. Additionally, we expect increased emphasis and utilization of alternative therapies. All prescribers will prescribe opioids safely and responsibly, and data analytics will be utilized for provider feedback as well as patient registries.

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 region has experienced a high incidence of prescription opioid-related deaths, as described in Section 2.1, substantiating our focus on chronic nonmalignant pain management. Standards and processes implemented during the course of this project will have a sustained, direct positive impact on our patients and the community by enabling providers to better address opiate abuse, reduce overprescribing and addiction, prevent diversion, overdose and opiate-related deaths.

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).

PDH Senior Management has established a three-year strategic plan, which includes a comprehensive quality improvement program. PRIME project goals and objectives align with our strategic focus on quality improvement.

Our Quality Oversight Committee (QOC) will monitor PRIME project implementation on a regular basis. The RHC Advisory Committee and Medical Director will be accountable for implementation in the RHCs. The Medical Staff and Nursing Council will direct hospital implementation. Each of these groups in turn is responsible for staff and provider adherence to provisions of the PRIME project. Proactive peer review will ensure provider adherence to program elements.

The Board of Directors and Senior Management will receive regular updates and provide high-level oversight.

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.

At PDH, we are fortunate to have a cohesive Medical Staff, all of whom practice on our relatively small campus. Relationships between physicians, administration, and the board are healthy, leaving no obstacles for a united front in addressing this project. Provider awareness is already high with eagerness to develop a comprehensive strategy. Patient access and clinical support personnel are poised for further adoption of processes and protocols that have been utilized but need more consistency and refining. Significant engagement has occurred at the patient-provider level, though comprehensive strategies and resources have been lacking. Stakeholder feedback will include: 1) Direct patient feedback from patient surveys already in place, and 2) community feedback/engagement from members included in the RHC Advisory and Quality Oversight Committees. PDH is participating in the Northern Sierra Opioid Coalition, which includes the following stakeholders: Plumas County Sheriff's Department, Probation, Mental Health, Public Health, Alcohol and Drug Department and county healthcare providers.

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.

PDH has established organizational expectations for cultural non-bias and respect of diverse cultural practices. We utilize phone translation services for non-English speaking patients and meet ADA requirements for those who are vision and hearing impaired. Our facility treats a large percentage of patients with multiple chronic health conditions, many of whom are of a low socioeconomic status. Patients are encouraged to report any bias in receipt of treatment and staff are subsequently provided further training, counseling or discipline as needed to address any infractions.

PDH accepts all payers including traditional and Managed Care Medi-Cal. All patients, regardless of ethnicity, socioeconomic status, or payer type, have access to all of our services. Language-specific literature will be distributed according to patient's first language preference. Disparities in access will be addressed through collaboration with the Public Health Department through our Community Health Assessment and our Community Health Improvement Plan. Since private physical therapists in our district do not take Medi-Cal, consideration of providing PT through our RHC will be given if economically feasible. All patients will have access to a

primary care physician, LCSW, Pain Specialist, Orthopedist, Spine Specialist, Telemed Psychiatry, and a Dietician through the RHC.

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.

PDH aims to maintain PRIME improvements through use of the following:

- Engage physician and staff project champions in the planning and implementation of project goals. These same champions will provide ongoing surveillance and maintenance of these specific improvements after PRIME project completion.
- An initial gap analysis will identify knowledge and skills enhancement opportunities. We will then develop a comprehensive training program to close those gaps. Ongoing continued education will be provided to staff and providers via staff meetings and grand rounds-style events.
- Regular analysis of data extracted from the EHR and CUREs reports to monitor safe prescribing practices and maximal opiate dosing.
- Ongoing proactive peer review process will monitor provider adherence with safe prescribing practices and other project goals. Recalcitrant providers will be disciplined if necessary.
- Maintain senior leadership support for PRIME project implementation tactics.
- Ongoing collaboration between our Medical Director and the Northern Sierra Opioid Coalition

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.*

☒ 2.6 – Chronic Non-Malignant Pain Management

A growing national awareness has occurred regarding opiate diversion, addiction, overprescribing, overdose, and opiate related deaths, which in turn has led to a variety of responses among healthcare professionals. PDH selected this project because Plumas County statistics pertaining to opiate-related deaths suggest alarming penetration of the “opioid epidemic” in our region.

PDH has experienced multiple issues including, increased rates of accidental overdose, aberrant patient behaviors during staff interactions, medication usage noncompliance, and early requests for renewal. Furthermore, we see an increased expectation for prescription opioids and increased narcotic diversion. Although offered, multi-modal therapies have been largely unaccepted by patients in favor narcotics as the sole pain management method.

In January 2016, the Northern Sierra Opioid Coalition formed to lead adoption of standardized safe-prescribing practices, expand access to medication-assisted addiction treatment (MAT), and increase access to naloxone across our region. PDH supports developing a comprehensive pain management program in collaboration with the Coalition’s efforts.

Reducing the issues outlined above will have a sustained positive impact on patients and the community. Our planned design and implementation approach includes:

- Referral Processes: Identify and enter into contract(s) with a pain specialist(s). (DY11)
- Clinical Pathways: Convene workgroup to review current processes, and develop standardized pain management program. Conduct outreach to community-based resources to assess multi-modal treatment options. Work with law enforcement to address narcotic diversion. (DY11 and DY12)
- Implement technology-enabled data systems: Hire I.T. staff to work with EHR vendor by integrating the care plan template and project metric reporting capabilities into EHR (DY12)
- Care Team Training: Providers and staff will receive ongoing training for the appropriate management of chronic pain. This will include evidence-based policies, procedures, and protocols. We will begin in DY12 but expect to continue into DY13.
- Collaboration: Medical Director will participate in ongoing Northern Sierra Opioid Coalition activities (DY11)

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

Target Population:

Our target population includes all current patients with prescription opioids for chronic pain, and those who will be newly diagnosed. We will begin implementation in the RHC, then move to the hospital emergency department and inpatient unit for coordination of care.

Vision of Care Delivery:

PRIME will enable PDH to provide high quality, patient centered care for appropriate treatment of chronic pain. The development of a standardized, evidence-based management plan will support our providers and staff with tools they need to better meet patients' needs. Identifying other community resources will help connect patients to alternative therapies. Providing training related to safe prescribing, use of alternative therapies, standard Pain Management Agreement parameters and the importance of scheduling pain focused follow-up visits to ensure timely refills and appropriate monitoring will contribute to improved pain control for patients, reduce opioid overuse, and reduce opioid-related emergency visits and hospitalizations.

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.
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.
Not 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.

Check, if applicable	Description of Core Components
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.
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.
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.

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

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

Section 9: Health Plan Contract (DPHs Only)

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

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

Section 10: Certification

☒ 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.	Develop referral sources for chronic pain specialty services	• Contract(s) with pain specialist (s)	2.6	July 2015-June 2016
2.	Develop draft uniform care plan that includes method to track multi-modal referrals and Pain Care Agreement tracking	• Convene action group to review literature and current protocols • Develop a draft care plan, including protocols, Pain Care Agreement and educational literature • Build flow sheet into EHR to track Pain Care Agreements • Develop tracking method for multi-modal referrals • Collaboration with Northern Sierra Opioid Coalition	2.6	July 2015-June 2016
3.	Finalize uniform care plan	• Pilot the care plan • Implement the care plan	2.6	July 2016-Dec 2016
4.	Develop and implement clinical and staff education on chronic nonmalignant pain management	• Convene a workgroup that includes expertise in chronic pain management • Develop education modules • Schedule and conduct staff training • Collaborate with Northern Sierra Opioid Coalition	2.6	July 2016-June 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
5.	Implement technology-enabled data systems	• Hire and train new I.T. staff • Work with EHR vendor to integrate the care plan into the EHR by developing a template • Work with EHR vendor to develop project metric reporting capabilities	2.6	July 2016-June 2017
6.	Implement clinical care coordination	• Develop a job description for a Clinical Care Coordinator to engage in this work • Hire and train a staff person • Assess current facility and community resources • Collaborate with Northern Sierra Opioid Coalition	2.6	July 2016-June 2017