



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

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

Eastern Plumas Health Care

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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 Eastern Plumas Health Care

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.

According to the Plumas County Mental Health Services Act FY 2014-2017 Three-Year Program and Expenditure Plan, adults and children in Plumas County have a wide range of mental health needs. The 2014 MHSA survey of community members revealed that 73% of respondents feel that sadness or depression is a large issue for adults and 53% feel it is an issue for children and youth/ while 71% felt that anxiety was a large issue for adults. Over one-third responded that suicide was a large issue in adults, and 20% believed suicide was an issue for children.

Behavioral Health. According to data between July 2014 and July 2015, the clinics within Eastern Plumas Health Care's service area served over 1,000 patients with a behavioral health diagnosis. Many of these patients are also in our pain management program; we are successfully managing a population that, historically, has seen a high instance of drug seeking and drug abuse behaviors. Behavioral health services (counseling and psychiatry/prescribing), particularly in combination with primary care, are essential to the proper care and management of these patients. The Skilled Nursing Facilities also report patients with behavioral health needs including dementia, depression and anxiety. Frequent issues noted are in the care and treatment of patients with dementia and behavior problems currently in need of or taking mood stabilizing agents.

Physical Health. According to data from OSHPD, cited by kidsdata.org, hospitalizations for mental health issues for those 5-19 years of age has been on the rise. In Lassen, Modoc, Nevada, Plumas and Sierra Counties from 2013 to 2014, the rate of mental health related hospitalizations per 1,000 rose from 3.5 to 4.1, while staying consistent statewide at 5.1.

Health Disparities. According to data from the California Health Insurance Survey, approximately 10 percent of the population is estimated to be uninsured in 2014 in Plumas County. More than 30% of the population is enrolled in Medi-Cal, with over 20% below the Federal Poverty Level. Additional survey data for Del Norte, Siskiyou, Lassen, Trinity, Modoc, Plumas and Sierra Counties indicates that 19.1% of the population needed help for emotional or mental health problems or the use of alcohol or drugs, with only 18.3 % being insured.

We are hoping to utilize the funding provided through PRIME to address the needs of these complex patients outlined above, particularly in regard to case management and resource linkage services between behavioral health and primary care.

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.

Plumas County's population is approximately 18,859. Its largest town is Portola, with approximately 1,957 residents. The town of Quincy, the county seat, has a population of 1,728, with a total surrounding area population of approximately 7,000.

Because of its isolated, frontier location, residents are further away from necessary specialists, and the 38% Medi-Cal population often lacks resources to travel in order to access these services. Portola is one hour away from the nearest large, urban hospital in good weather. In winter, this time is often doubled and sometimes the roads are impassable. Because of the isolated location it is difficult to attract quality providers, especially ones that will commit to staying in the area. This causes a lack of continuity of care for patients.

Income. The median household income is \$34,134. 22.5% of individuals are below the poverty level. The median house value is \$155,500. 4.4% of the population is under 5 years of age; 17.2% are under 18; and, 24.7% are 65 and over.

Race/Ethnicity and Language. The County's population is comprised of 84% Caucasian, 8% Hispanic, 3% Native American, and the balance from Other race/ethnicity groups (*US Census 2010, Population Estimates Program*). 8.8% of the population speaks a language other than English.

Age. The population is slightly older than the state overall, with an average age of 49 (compared to 35.2 statewide). The age breakdown is as follows:
0-18 years: (17.2%)

19-64 years: (58.1%)
65 and over: (24.7%)

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.

Eastern Plumas Health Care (EPHC) is licensed as a Critical Access Hospital and its clinics are licensed Rural Health Clinics and currently has three clinic sites located in Portola, Graeagle and Loyalton, an acute care hospital with 9 beds, a 24/7 physician staffed emergency room, 24 hour ambulance service, and two Skilled Nursing Facilities with a combined total of 66 beds.

Specialty services include cardiology, dentistry, emergency medicine, family practice, gastroenterology, gynecology, internal medicine, obstetrics, orthopedics, pain management, physical medicine and rehabilitation, podiatry, radiology, surgery, telemedicine and urology.

Eastern Plumas Health Care's payer mix is as follows:

- 42% - Medicare
- 38% - Medi-Cal/Managed Medi-Cal
- 16% - Commercially Insured
- 4% - Other

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

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

In 2015, EPHC launched use of the Healthland Centriq electronic medical records system. This system allows for quality reporting and the ability to streamline the approach to meaningful analytics.

Data Collection: The Healthland Centriq system will be utilized for collection and processing of all system data. This includes provision of an integrated health information reporting system for both individual patients, as well as for designated populations.

Reporting: EPHC can export and upload information from the Healthland Centriq system to other reporting mechanisms to meet reporting requirements. This has been used as we've participated in comparison reports with other district hospitals,

PQRS reporting, telemedicine programs, DSH programs, SHIP grants, OSHPD reports, cost reports, BOD reports, monthly financial reports, budgets and internal and external audits.

Monitoring: We can utilize information from Centriq to filter information and pull the necessary data required to support PRIME clinical quality reporting requirements. We use Microsoft Excel spreadsheets as a tool to analyze and share information as needed.

Barriers: Our primary barrier to meeting PRIME reporting requirements is due to the small size of our analytics team and available staff for this function. We have one FTE Clinical Informatics Specialist, who also provides needed and ongoing training and support for the EMR to providers and staff. She also works closely with the IT department for necessary data collection and reporting. It will be a challenge to incorporate the PRIME reporting activities into their existing responsibilities. Therefore, it may be necessary to incorporate additional FTEs to assist with this function.

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.*

The primary goal for EPHC is to improve the physical and mental health of our patients by coordinating and integrating their care. As part of PRIME, EPHC intends to implement standardized, evidence-based screening tools and referral processes, improve the level of integration of primary care with behavioral health, streamline

appointment and rooming processes for tele-psychiatry services and implement a sustainable case management process.

As a secondary goal, EPHC intends to implement a Patient-Centered Medical Home (PCMH) model, primarily through the addition of case management, in order to guide patients and their families through the full continuum of care, including a focus on improved care management and care transitions to reduce avoidable utilization. This will support delivery system transformation in that EPHC will be better able to provide whole-person care in the setting that is best suited to the patient's clinical and social needs.

*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 five specific aims for EPHC's PRIME participation:

1. Expand the capacity to identify and treat mild to moderate behavioral health needs in the primary care setting by:
 - a. Developing a collaborative care program in the three primary care clinics to address mild to moderate adult and child behavioral health conditions.
 - b. Shift focus to screening for behavioral health conditions using standardized tools (e.g. PHQ-2, SBIRT) rather than relying on individual, and therefore variable, provider assessment.
 - c. Referral of only those patients who are not improving or are too complex with moderate to severe problems to either telemedicine or Plumas County Mental Health (PCMH), depending on diagnosis and acuity via agreed upon protocols.
2. Establish expanded case management programs and pilot project in the primary population center of the service area:
 - a. Hire case manager who can focus on patient outreach, ensuring needs are met and that patients are following up with appointments, adhering to medications, etc.
 - b. Add non-licensed staff to provide patient navigation, financial screening and eligibility, resource linkage and liaison activities with PCMH, community-based resources and other supports.
3. Streamline the tele-psychology and tele-psychiatry program:
 - a. Rely on on-site staff in an evidence-based, collaborative care model to provide the majority of the care, referring more complex and treatment non-responsive patients to telemedicine or PCMH as appropriate.
 - b. Use of Medical Assistant (MA) to coordinate visits.

4. Expand the Portola Medical Clinic to include staff offices, exam/consult rooms, a telemedicine suite, and conference/group meeting room to accommodate above program expansion.
5. Implement ongoing training programs for sustainability and success of the overall program.
 - a. Training in roles and processes in the collaborative care model, including individual team member roles, clinic flow, use of screening and measurement tools.
 - b. De-escalation training for all staff.
 - c. Mental Health 101 and/or Mental Health Emergencies for clinical staff

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;*

EPHC has selected the integration of behavioral health and primary care (Project 1.1), as this directly corresponds to our project aims and will enable us to develop the necessary infrastructure to integrate behavioral and physical health services, while ultimately developing a centralized, complex care management program.

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*
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 the end of the five years, we envision that patients served by EPHC will be routinely and properly screened for mental health and substance use disorders and will receive the proper clinical and support services when needed in a care setting that is optimal for their needs and ultimate ongoing success. We will have the infrastructure and staff to identify co-occurring physical and behavioral health needs and will provide seamless connections to services across the health care system.

By having this infrastructure in place, we would anticipate decreasing avoidable admissions and unnecessary ED use and increased reliance on community-based resources and services, including primary care as applicable, to keep people healthier and in their homes.

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.

Behavioral health data regarding our community, as described in our response to Section 2.1, emphasizes the rationale to focus on behavioral health and primary care integration within our health care delivery system. Specifically, enhancing our ability to identify behavioral health conditions among our patients and develop standardized processes to connect patients to treatment will improve our ability to provide whole-person care to our patients. It will also decrease the amount of mental health and substance use disorders that go unacknowledged or untreated, since many patients have co-occurring physical and behavior health diagnoses, ensuring that behavioral health needs are identified and addressed and ultimately improving health outcomes for the population that we serve.

Improving the organization and delivery of complex care management services should address local needs by improving health outcomes, as well as the overall patient experience of care. We also anticipate reduced usage of the emergency department as patients are better managed in the community and have additional resources and support services to enable self-management.

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).

Our patients are at the heart of Eastern Plumas Health Care's mission. We provide patients with the best quality health care as cost-effectively as possible. We value our patients as individuals. Patient safety, comfort, and dignity come before all other considerations. We work compassionately to address their physical, emotional, and spiritual needs, offering comprehensive care throughout their lifetime. This philosophy will be the core component for development and sustainability of our PRIME project.

As a district hospital, our Board members are individually-elected public officials. Our board members are knowledgeable, responsible individuals who ensure that our hospital remains true to its mission, stays economically viable, and maintains a long-term vision in keeping with the changing health care needs of our community and the need to reduce unnecessary utilization. This Project supports our strategic plan goal of providing access to care for all of our patients by expanding special

services and telemedicine services. Our Board of Directors and CEO, who set EPHC's strategic plan goals, are also committed to robust engagement and oversight of PRIME-related activities.

As part of our PRIME-related activities, a Prime Advisory Committee (PAC) will be immediately formed, in conjunction with Plumas County Mental Health, MHSA stakeholders and our Board of Directors, in order to be certain that all stakeholders and beneficiaries of behavioral health services have input into the design and development of an integrated physical and behavioral health model within Plumas County.

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.

EPHC will ensure that stakeholders and beneficiaries have multiple opportunities to be engaged in PRIME planning and implementation. This will be achieved by including a seat for the health care consumer representative on the Prime Advisory Committee (PAC), as well as for a member of Plumas County Mental Health. We will also allow an opportunity for questions and comments from the public during committee meetings in order to ensure that consumers have an opportunity to provide substantive input and feedback into PRIME-related planning.

Additionally, we will augment our already established relationships with community-based organizations that provide support services to our patients. We will work with these stakeholders as part of PRIME planning and implementation and will identify additional organizations that may need to be added to these planning activities.

We will set up a PRIME Advisory Committee of representatives from the hospital, county mental health, and possibly the community, in order to monitor on an ongoing basis the success of the program in integrating primary and behavioral health care services.

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.

EPHC has a history of implementing approaches to meet the needs of our population. This includes working to ensure that providers and staff reflect the diversity of our patients and that all of our patients have access to health information in both English and Spanish as necessary. We intend to continue these

activities as part of our commitment to providing culturally competent service and care.

The US Census Bureau estimates that only 8.8% of the population of Plumas County speaks a language other than English at home, with the predominant language being Spanish. However, Plumas County has no threshold language, per the Department of Health Care Services (DHCS) formula.

In an effort to reduce healthcare disparities amongst all patients of Eastern Plumas Health Care, this project will allow for increased access to behavioral health services currently lacking elsewhere in the county, aside from telemedicine. Additionally, staffing preferences, particularly for the Case Manager and telemedicine Medical Assistant positions, will include a bi-lingual (Spanish) individual to further decrease disparities for our Hispanic population.

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.

Our plan for sustainability of PRIME initiatives includes the following:

- Engaging providers and staff in a collaborative care program in all primary care clinics to address mild to moderate adult and child behavioral health conditions.
- Implementation of formal referral processes utilizing evidence-based guidelines for appropriate level of care for SMI patients.
- Regular meetings and case planning between EPHC and PCMH to coordinate care for mutual patients.
- Improve sharing of authorized patient information, potentially through shared access to records and documentation within both EMR systems (EPHC and PCMH).
- Ongoing care coordination through case management staff to ensure successful treatment and outcomes for identified patients.
- Providing intensive education and training for all staff in HIPAA, mental health 101, crisis intervention, de-escalation and stabilization techniques, beginning with a process to identify gaps in knowledge and skills and developing varied learning opportunities to address these gaps.
- Ensuring ongoing support from senior leadership for designing and executing strategies related to PRIME implementation over the project period.

Section 4: Project Selection

The PRIME Projects are organized into three Domains:

- Domain 1: Outpatient Delivery System Transformation and Prevention
- Domain 2: Targeted High Risk or High Cost Populations
- Domain 3: Resource Utilization Efficiency

The PRIME program will provide incentive payments to participating entities that commit to implementing 5-year projects within the PRIME domains and as further described in [Attachment II -- PRIME Program Funding and Mechanics Protocol](#). The required set of core metrics for each project is outlined in [Attachment Q: PRIME Projects and Metrics Protocol](#). The purpose of this section is for applicants to indicate which projects they will implement and to describe the approaches to implementation.

Selections must comply with the requirements of the STCs and the Attachments Q and II delineating the PRIME program protocols.

Designated Public Hospitals (DPHs) are required to implement projects from all three Domains. DPHs must select at least nine projects, of which six are specifically required:

- Select at least four projects from Domain 1 (Projects 1.1, 1.2, and 1.3 are required);
- Select at least four projects from Domain 2 (Projects 2.1, 2.2, and 2.3 are required); and,
- Select at least one project from Domain 3.

District/Municipal Public Hospitals (DMPHs) are required to select at least one project to implement. DMPHs may select their project(s) from any of the three Domains.

Instructions

For Sections 4.1 - 4.3, click the box(es) that correspond to the project(s) you will undertake. In addition, click the boxes that correspond to the core components you will adhere to in order to achieve the objectives of the project. Note that core components selected are not required; they are meant to guide project execution and serve as recommendations only.

Answer all of the questions below for each selected project. Provide narrative responses in the spaces marked “[Insert response here]”:

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

2. Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]
3. **For DMPHs (as applicable)**, indicate which project(s) your entity is selecting that will require infrastructure-building process measures and complete the supplemental document (Appendix) to identify and describe your proposed process measures.

For DMPHs requiring infrastructure building metrics that are approved in the Prime Project Plan, 75% of PRIME funding for DY 11 will be based on the achievement of the approved DY 11 infrastructure building metrics through the final year-end report. Up to 40% of the total PRIME funding for DY12 will be based on the achievement of the approved DY 12 infrastructure building metrics through the mid-year and final year-end report. The proposed Process Measures should meet the following criteria:

- *Specific*
- *Measurable: Must be able to demonstrate progress throughout the duration of the process metric measurement period.*
- *Evidence-based: Measures should have a strong evidence-base that can linked process to outcomes.*

Section 4.1 -- Domain 1: Outpatient Delivery System Transformation and Prevention

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

According to the national Alliance on Mental Illness Currently, one-quarter of adults experience a mental illness in a given year, and more than half receive no treatment. More than 70% of visits to primary care physicians are related to psychosocial issues. EPHC selected this project because of the prevalence of behavioral health needs in our county, as described in Section 2, and because we currently lack the infrastructure to routinely identify these needs. Improved management of these conditions could improve health outcomes overall.

Our planned implementation approach includes:

- *Collaborative Care Program:* Develop a collaborative care program in the primary care clinics to address mild to moderate adult and child behavioral health conditions. This will require hiring additional staff who will be onsite in the primary care setting to be available for “warm handoffs” from providers. In addition, we will shift to screening for behavioral health conditions using standardized tools and providing additional

services (such as referral to telemedicine) for those not improving as expected through regular caseload review. We intend to work on this program in DY11-15.

- *Case Management Program:* Hire case manager who can focus on patient outreach, ensuring needs are met and that patients are following with appointments, adhering to medications, etc. Add non-licensed staff to provide patient navigation, financial screening and eligibility, resource linkage, and liaison activities with PCMH, community based resources and other supports. We intend to implement this program immediately in DY11, and continue building in subsequent funding years.
- *Telehealth Program:* Develop a process to refer more complex and treatment of non-responsive patients to the tele-psychiatrists/psychologists. Verify that contracted tele-psychiatrists are licensed in CA, have active and non-restricted DEA licenses and are able to e-prescribe, are available to support EPHC staff during hours of operation and are able to provide continuity of care for patients. Add e-consult component to support the primary care providers in managing patient's behavioral health conditions and making specialist referrals. We intend to implement this program immediately in DY11, and continue building in subsequent funding years.

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

Target Population. Because of the proposed collaborative care model associated with this project, we have identified several target populations. With implementation of PHQ-2 and SBIRT screenings, we expect the target population to include all our adult patients, and pediatric patients as indicated by the literature. We intend to begin this work in the primary care setting, while working collaboratively with our emergency department for connecting patients to services. We anticipate that the target population for referral will be a subset of those who have a positive behavioral health needs screen. This is because some patients may not need referrals (e.g. a patient who has mild depression may continue to see their PCP).

Vision for Care Delivery. PRIME will enable EPHC to accomplish several key objectives that are central to our ability to provide high-quality, patient centered care. First, routine screenings will enable us to ensure that we assess needs beyond just physical health. The development of common clinical pathways will support providers and staff with the tools they need to better meet all aspects of their patients' needs.

Identifying community resources and working closely with PCMH will help us connect our patients to care and services beyond the four walls of our health system. This is particularly important because EPHC does not currently have sufficient capacity to meet all of our patient's behavioral health needs. Providing

staff training related to the importance of behavioral health screening and patient engagement will contribute to improved population management and reduced fragmentation of care for patients.

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

Check, if applicable	Description of Core Components
Applicable	1.1.1 Implement a behavioral health integration assessment tool (baseline and annual progress measurement)
Applicable	1.1.2 Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration, the Collaborative Care Model, or other Integrated Behavioral Health (IBH) resources from SAMHSA)
Applicable	1.1.3 Integrate appropriate screening tools and decision support into the emergency department (ED) to ensure timely recognition of patients with mental health and substance use disorder problems. Enhanced access to primary care and/or to behavioral health specialists will be integrated into discharge planning for these patents. Use of 24-7 care navigators (e.g., Community Physician Liaison Program) may be used to support linkages to primary care providers (PCPs), mental health (MH) and substance use disorder (SUD) specialists and behavioral health and other community services through the discharge process.
Applicable	1.1.4 Integrate physical and behavioral health, either through implementation of a new program or an expansion of an existing program, from pilot sites to hospital and health system primary care sites or from single populations to multiple populations (e.g., obesity, diabetes, maternal, infant, and child care, end-of-life care, chronic pain management).
Applicable	1.1.5 Patient-Centered Medical Home (PCMH) and behavioral health providers will: <ul style="list-style-type: none"> • Collaborate on evidence based standards of care including medication management and care engagement processes. • Implement case conferences/consults on patients with complex needs.
Applicable	1.1.6 Ensure coordination and access to chronic disease (physical or

Check, if applicable	Description of Core Components
	behavioral) management, including self-management support to patients and their families.
Applicable	<p>1.1.7 Ensure systems are in place to support patient linkages to appropriate specialty physical, mental and SUD services. Preventive care screenings, including behavioral health screenings (e.g., PHQ-2, PHQ-9, SBIRT), will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including the provision of brief interventions (e.g., motivational interviewing techniques) to ensure access for further evaluation and treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.</p>
Applicable	<p>1.1.8 Provide cross-systems training to ensure effective engagement with patients with MH/SUD conditions. Ensure that a sufficient number of providers are trained in SBIRT and/or in other new tools used by providers to ensure effectiveness of treatment.</p>
Applicable	<p>1.1.9 Increase access to Medication Assisted Treatment (MAT) for patients with alcohol and opioid addiction to assist in stabilizing their lives, reducing urges or cravings to use, and encourage greater adherence to treatment for co-morbid medical and behavioral health conditions. For alcohol use disorders these medications include naltrexone, acamprosate, and disulfiram. For opioid addiction, medication assisted treatment (MAT) includes maintenance treatment with methadone and buprenorphine.</p>
Applicable	<p>1.1.10 Ensure the development of a single treatment plan that includes the patient’s behavioral health issues, medical issues, substance abuse, social and cultural and linguistic needs. This includes incorporating traditional medical interventions, as well as non-traditional interventions such as gym memberships, nutrition monitoring, healthy lifestyle coaching, or access to culturally and linguistically appropriate peer-led wellness and symptom management groups.</p>
Applicable	<p>1.1.11 Ensure a culturally and linguistically appropriate treatment plan by assigning peer providers or other frontline worker to the care team to assist with care navigation, treatment plan development and adherence.</p>

Check, if applicable	Description of Core Components
Applicable	<p>1.1.12 Ensure that the treatment plan:</p> <ul style="list-style-type: none"> • Is maintained in a single shared Electronic Health Record (EHR)/ clinical record that is accessible across the treatment team to ensure coordination of care planning. • Outcomes are evaluated and monitored for quality and safety for each patient.
Applicable	<p>1.1.13 Implement technology enabled data systems to support pre-visit planning, point of care delivery, care plan development, population/panel management activities, coordination and patient engagement. Develop programs to implement telehealth, eReferral/eConsult to enhance access to behavioral health services.</p>
Applicable	<p>1.1.14 Demonstrate patient engagement in the design and implementation of the project.</p>
Applicable	<p>1.1.15 Increase team engagement by:</p> <ul style="list-style-type: none"> • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on care model.
Applicable	<p>1.1.16 Ensure integration is efficient and providing value to patients by implementing a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.</p>

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):		
Domain 1 Total # of Projects:		1

Section 5: Project Metrics and Reporting Requirements

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

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

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

processes and infrastructure to support MCP achievement of quality improvement efforts when aligned with PRIME projects.

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

Section 6: Data Integrity

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

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

Section 7: Learning Collaborative Participation

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

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

Section 8: Program Incentive Payment Amount

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

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

- DY 11 \$ 1,500,000.00
- DY 12 \$ 1,500,000.00
- DY 13 \$ 1,500,000.00
- DY 14 \$ 1,350,000.00
- DY 15 \$ 1,147,500.00

Total 5-year prime plan incentive amount: \$ 6,997,500.00

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.

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
	tele-psychiatry program	coordinate patient’s care with the case manager <input type="checkbox"/> Develop process for telemedicine coordinator and case manager to work collaboratively to ensure that patient’s care plan is clearly communicated between specialty and primary care providers <input type="checkbox"/> Recruit and hire a Medical Assistant (MA) specifically for the telemedicine program to ensure visit details are handled and that the telemedicine coordinator can focus on care coordination for these patients <input type="checkbox"/> Use Medical Assistant (MA) to manage telehealth visits (e.g. handle vitals, take notes for PCP) <input type="checkbox"/> Add e-consult component that helps support the primary care providers in better managing mild to moderate behavioral health conditions and ensures referrals to specialists are high value		Jan-June 2017 July 2016 August 2016 July-Dec 2016
4.	Building addition to support program expansion	<input type="checkbox"/> Hire architect for building expansion <input type="checkbox"/> Prepare architectural plans <input type="checkbox"/> Prepare RFP for addition to existing medical clinic building to support program expansion and additional activities <input type="checkbox"/> Review bids and award contract for building expansion <input type="checkbox"/> Start to finish construction	1.1.4, 1.1.5	June 2016 July-Aug 2016 Sept 2016 Oct 2016 Nov 2016-

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
				May 2017
5.	Identification and deployment of clinical and staff education on behavioral health	<input type="checkbox"/> Reach out to Plumas County Mental Health regarding training opportunities and recommendations for staff <input type="checkbox"/> Develop any internal, ongoing curricula modules and method of delivery <input type="checkbox"/> Schedule and conduct trainings. <input type="checkbox"/> Assess effectiveness of trainings	1.1.15	July 2016 Jan 2017 Jan-June 2017 Jan-June 2017
6.	Demonstrate patient engagement in the design and implementation of the project.	<input type="checkbox"/> Develop patient surveys for targeted feedback of service design and implementation with assistance of PRIME Advisory Committee (PAC) <input type="checkbox"/> With input from PRIME Advisory Committee (PAC) members, develop and incorporate non-traditional interventions into a single treatment plan to include the patient's behavioral health issues, medical issues, substance abuse, social and cultural and linguistic needs <input type="checkbox"/> Design workflows and documentation to reinforce patient engagement in plans of care	1.1.14 1.1.10	Jan 2017 March 2017 Jan 2017 Jan 2017