



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

REVISED Application due: **by 5:00 p.m. on June 1, 2016**

Table of Contents

Table of Contents.....	2
General Instructions.....	3
Scoring.....	3
Section 1: PRIME Participating Entity Information.....	4
Section 2: Organizational and Community Landscape	4
Section 3: Executive Summary	8
Section 4: Project Selection.....	13
Section 4.1 -- Domain 1: Outpatient Delivery System Transformation and Prevention.....	14
Section 4.2 -- Domain 2: Targeted High-Risk or High-Cost Populations	19
Section 5: Project Metrics and Reporting Requirements	23
Section 6: Data Integrity	24
Section 7: Learning Collaborative Participation.....	24
Section 8: Program Incentive Payment Amount.....	25
Section 9: Health Plan Contract (DPHs Only)	25
Section 10: Certification	25
Appendix- Infrastructure Building Process Measures	26

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 Southern Mono Healthcare District d/b/a Mammoth 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.

Mammoth Hospital (MH) serves the residents and visitors of the rural area of Mono County (MC) and rural counties beyond. MC is located on the east side of the Sierra Nevada mountain range of California. The County spans 3,132 square miles with the closest urban community 2-3 hours north in another state (Nevada) or 5-6 hours south in Southern California. There are ~14,000 full time residents (4.5 people per sq/mi) in MC with an influx of over 1 million visitors in each of the winter and summer seasons. The health disparities and needs of the community are as follows:

1. *Behavioral Health:* In 2015 MH treated approximately 1,930 MC residents with behavioral health diagnosis (18% are Medicaid) – thus 14% of the population is suffering from a behavioral issue. 78% of the BMH diagnoses are depression, anxiety/stress, substance abuse, and insomnia/sleep disorders. The emergency department visits for BMH diagnosis have quadrupled over the last 3 years to 670 in 2015 and Medicaid patients accounted for 341 of the 2015 visits (51%).
2. *Chronic Pain:* MC residents also suffer from chronic pain conditions due to the many outdoors activities and harsh winter conditions. In 2015 MH treated approximately 2,665 Mono County residents for chronic pain (16% are Medicaid) – approximately 19% of the population. The emergency department visits for chronic pain diagnosis have doubled over the last 3 years to 511 in 2015 and Medicaid patients accounted for 223 of these visits (44%).

3. *Health Disparities:* MC residents are challenged with the geographic isolation which makes accessing some health care services difficult. In addition, approximately 28% of the population is Hispanic or Latino. Finally, the 2014 census indicates that 11% of the population lives in poverty.
4. *Access and Continuity of Care:* Given the rural setting of the community and the limit to professional health services, access and continuity of care is a challenge for MC residents. Due to the tourist nature of the community, there are a large number of residents who work in the service industry and often have multiple part time jobs with no healthcare benefits. The 2014 census reflects 21% of the residents are without health insurance. In November 2013 most MC Medi-Cal beneficiaries migrated to one of two managed care plans. The initial enrollment was 1,146 beneficiaries and with the expansion of Medicaid that number has more than doubled to 2,496 representing 18% of the total MC population.

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.

Mammoth Hospital (MH) serves the rural community of Mono County (MC). MC has 1 incorporated town, Mammoth Lakes, which is home to nearly 60% of the county's residents. MH is located in the Town of Mammoth Lakes. Mammoth Mountain Ski Resort is located in the Town of Mammoth Lakes and attracts visitors both winter and summer. MH and Mammoth Mountain Ski Resort are the two primary employers in town. The demographics of MC are as follows:

1. *Income:* According to the 2014 census data, the median household income in Mono County is \$61,814 which is consistent with the state of California. Additionally the 2014 census data reports 11% of the residents are in poverty.
2. *Primary Language:*
 - a. 75.4% English
 - b. 21.7% Spanish
3. *Race in Mono County:*
 - a. 66% are White
 - b. 28% are Hispanic
4. *The age breakdown in Mono County is as follows:*
 - a. 0-18 years (21.02%)
 - b. 19-64 years (68.54%)
 - c. 65 and over (10.44%)

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.

Mammoth Hospital (MH) is a Critical Access Hospital (CAH) with the closest multispecialty full service hospital 170 miles to the north (Nevada) and 300 miles to the south (Southern California). We have 17 licensed acute hospital beds, broken down as 2 intensive care beds, 15 medical/surgical beds, and 2 labor and delivery beds.

Mammoth Hospital opened in 1978 by a group of local Mammoth residents who raised money for a hospital. The original 20,000 square foot hospital was expanded in 2007 to 38,000 square feet and it houses an emergency department, surgery center, fully digital medical imaging center, and a two-bed labor and delivery unit. MH also owns and manages two Rural Health Clinics providing primary care, orthopedic, and dental care services in the Town of Mammoth Lakes and the community of Bridgeport. MH has a hospital based General Surgery specialty clinic and contracts with several part-time specialty providers to facilitate outpatient specialty referrals for our patients. Specialists include urology, cardiology, ENT, dermatology, behavioral health, podiatry, and spine care.

In 2014 Mammoth Hospital joined forces with other rural health providers to form the National Rural ACO (NRACO) to learn and evolve our healthcare delivery into value-based care for the Medicare population.

Key Statistics (2015):

- i. 583 inpatient admissions
- ii. 78,987 lab and imaging tests
- iii. 1,123 surgeries
- iv. 8,836 emergency department visits
- v. 40,883 physician clinic visits

Payer mix (2015):

- i. 19.9% Medicare
- ii. 21.7% Medi-Cal
- iii. 52.7% Private insurance
- iv. 1.7% Uninsured
- v. 5.0% 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.

Mammoth Hospital currently tracks quality reporting metrics for the hospital activities and has recently expanded quality reporting in the outpatient physician practices. The current Quality Department resources and new resources added will support PRIME clinical quality reporting requirements.

1. *Data Collection.* Mammoth Hospital has dedicated report writers and analysts who continually mine the various information systems to create meaningful data for management decision making. These individuals have developed expertise over the years to identify anomalies in the data and report areas requiring management's attention.
2. *Reporting.* Mammoth Hospital uses a range of dashboards and reports to track performance. Automated reports have been generated for regular daily, monthly, or quarterly distribution.
3. *Monitoring.* Mammoth Hospital has a dedicated quality department that tracks and monitors quality metrics for both the hospital and physician clinic practices. These results are reported to a Performance Improvement Committee and then to the Board of Director.
4. *Potential Barriers.* The most significant barrier to meeting the PRIME reporting requirements is the small size of our reporting and analytics team members, who will have to incorporate the PRIME reporting activities into their existing responsibilities. In anticipation of this need we have established a dedicated Population Health Team in which an analyst was added to help with the reporting and monitoring of key data elements. Additional members were added to the Population Health Team such as a project manager and an RN care coordinator. We will continue to monitor the work load and add additional resources needed to ensure success of the PRIME projects. Mammoth Hospital is also in the final vendor negotiations to install an enterprise wide electronic health record (EHR) – targeted for go live in the fall of 2017. Moving to one EHR for the entire system will significantly improve the reporting capabilities under PRIME.

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.*

Mammoth Hospital lives the mission to promote the well-being and improve the health of our residents and visitors through a "Patients First" mentality. The initial push to provide innovative care started when the organization joined in the NRACO in 2014 as a founding member. Since then, the organization has developed goals and objectives to support system delivery transformation and change management. Mammoth Hospital will continue to focus on a movement towards population health management in order to better care for the health needs and disparities of those in the community. The organization as a whole is focused on better care coordination and developing programs and services to address behavioral and physical 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.*

Mammoth Hospital has three overarching aims for PRIME participation which will contribute to the overall transformation of our health system: (1) to improve access to care, (2) to improve care coordination efforts and continuity of care, and (3) implement standardized assessment tools and care plans that are evidenced based.

- a. *Access* – improve limitations of access to professional health services (BMH and Chronic Pain), develop alternatives to deal with: rural/geographic barriers, low income population and large Hispanic population, identify and utilize community resources
- b. *Continuity of Care* – develop cross functional care development, standardized referral processes and develop relationships, ensure

adequate staffing, develop improved discharge planning and care plans, implement full-bodied care

- c. *Assessment* – utilize screening tools and evidenced based care plans develop consistent standardized care for our patients

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;*

Mammoth Hospital selected the integration of primary care and behavioral health (Project 1.1) and chronic pain management (Project 2.6). These two projects directly correspond with our goals of improving continuity and access to care while addressing the unmet mental and behavioral health concerns within the community. Research, development, education, implementation and continuous evaluation will enable us to set expectations as we transform long-term.

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*

Mammoth Hospital has identified mental/behavioral health and chronic pain management as two areas of our healthcare delivery system that need to be addressed. Given Mammoth Hospital's rural location we do not have readily available access to a pain management specialist. As with the rest of the nation, we are dealing with substance abuse and dependency issues on opioid prescription drugs. Some chronic pain patients have interrelated mental and behavioral health issues such as these substance abuse and dependency. The two projects will help us integrate our behavioral health services into primary care while enabling us to address specific behavioral health concerns with chronic pain patients. These two PRIME projects will also jointly allow us to increase access to care while improving our care coordination efforts through system wide standardization.

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.*

Mammoth Hospital strives to be the leader in practice transformation as it pertains to critical access hospitals in California. At the end of five years, we plan to have our patients receiving the right care at the right place at the right time. We will have an infrastructure developed to spearhead continuous practice and system transformation with a constant commitment to change

management. We also anticipate decreasing avoidable utilization through increasing primary care relationships through care coordination efforts. We believe that PRIME will enable us to pilot alternatives with a smaller population with the goal of extending our successes to the entire community we serve.

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.

MH identified 1,930 MC residents that were treated for BMH conditions in 2015 (18% are Medicaid patients). These individuals generated 3,901 visits to our facilities. In 2013 we experienced a significant growth in emergency visits for BMH conditions (the 5 years prior averaged about 155 and grew to 670 visits in 2015). Medicaid patients visiting the emergency department accounted for 341 of those visits (51%). Of the total visits, 78% of these individuals are suffering from depression, anxiety/stress, substance abuse, or insomnia. MC has limited tele-psych access which needs to be reserved for the most severe mental health conditions. Since the majority of the diagnoses are of lower severity, the community would benefit from better management of care by the PCPs. Adopting standardized tools, evidenced based care plans and additional clinical staff resources to aid the PCP's should address the needs of the community.

Most of the chronic non-malignant pain patients seek relief from their primary care providers. The PCPs are concerned that patients are not improving and have become dependent on opioid medications. MH treated 2,665 patients for pain related diagnosis. In addition, we identified 263 MC residents who were prescribed opioid type medications by our PCPs over a recent two month period. The providers need to adopt consistent evidence based care plans for chronic non-malignant pain and implement standardized tools to monitor the effectiveness of the care provided. PRIME will facilitate care teams to add additional treatment options to improve patient outcomes without creating opioid medication dependence.

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).

Mammoth Hospital's organizational goals are directly aligned with the patients and community we serve. As a DMPH, our board members are individually-elected public officials. Board members are knowledgeable about both the health care

needs of our community and the need to efficiently utilize resources. The board has been educated on the PRIME initiatives and has approved support for these initiatives. The goals of the organization include increasing care coordination and partnering with our patients to improve their health and managed their chronic conditions. Quality improvement goals are another major focus for the hospital to meet the patients' and community's needs. Automated reports will be developed along with standardized processes and procedures. This will enable us to monitor outcomes while providing feedback and making data driven decisions. Mammoth Hospital also developed project teams for the PRIME initiative who will report to the Senior Administrative Team. The hospital has a Performance Improvement Committee which is charged to oversee and monitor the improvement activities of the organization.

In response to the needs of participating in both the NRACO (for Medicare patients) and PRIME (for Medi-Cal patients) Mammoth Hospital has created a Population Health Department and has hired initial staff to take responsibility for the success of these projects. Additional resources may be added to meet the needs of these programs, especially care coordination staff.

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.

Mammoth Hospital will engage both internal and external stakeholder in the PRIME projects. Each PRIME project will have a project team which will report statuses, data, concerns and successes to the Senior Administration Team. The Senior Administration will then direct information to the Performance Improvement Committee and the Board of Directors. Routine meetings will be held with each project team and individuals in order to develop, plan and implement each part of the projects. Each of the projects will have a patient advisory member to ensure we implement processes that will be beneficial to the patient. Since both of the PRIME projects have significant involvement by the primary care providers, regular discussions and reports will be presented at their provider meetings. Mammoth Hospital is working collaboratively with the Mono County Health Department to perform a Community Needs Assessment. A review of the needs assessment will further evolve activities to meet the needs of the community.

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.

Mono County has a large Hispanic population. As the only healthcare provider in the County, Mammoth Hospital has a dedicated bi-lingual interpreter team and hires bi-lingual staff for the primary care clinics to ensure we properly communicate and address the patients' healthcare concerns. We translate all patient documents and educational materials into Spanish to promote the best possible health outcomes. We recently hired an RN Care Coordinator who is fluent in Spanish and has had great success at helping these patients develop achievable goals to improve their health. We also contract with an interpretation and translation company for other languages.

As for patient engagement, Mammoth Hospital offers programs such as patient/self-advocacy, spiritual care, customer service and volunteer services. Another goal of Mammoth Hospital is to implement and use an array of telehealth and tele-monitoring services. We also have the capability to offer trainings to employees on how to engage specific patients based on things such as cultural differences and diversities.

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.

The organization chose to become ISO9001 certified through the DNV accreditation organization. Over the past few years we have been transforming all aspects of our facility to use standardized processes to reduce variation which often results in less than ideal health care outcomes. In addition, the organization has implemented a "Spiritual Care" program to address the non-clinical aspects of patient care. This program recognizes the "whole" person needs. These are just a few examples of activities that have laid the foundation for continuous improvement which will promote sustainability of the PRIME projects. The PRIME activities will be supported by:

- i. Senior leadership and Board support for the design and execution of the strategies
- ii. Engage providers and staff in the planning and implementation
- iii. Education and training to staff and providers on the projects and new tools/care plans
- iv. Produce reliable data for decision making throughout the projects

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)

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]

Rationale: Mammoth Hospital (MH) selected this project based on the lack of behavioral mental health providers and the volume of lower acuity behavioral health diagnoses needs. In 2015 MH treated approximately 1,930 MC residents with BMH diagnosis. These patients' generated 670 emergency department visits and over half were Medicaid patients (341 visits). 78% of the BMH patient visits are depression, anxiety/stress, substance abuse, and insomnia/sleep disorders.

Project Design: With our remote location, it is clear that the primary care providers need to manage the care of patients with the lower acuity BMH diagnoses. Because of the prevalence of behavioral health needs in our county and community, improving management of these conditions through integrating behavioral health into the primary care setting would allow us to develop

mechanisms to care for these patients and inevitably improve overall health outcomes.

Planned Implementation Approach:

- a. *Referral Processes:* MH will reach out to other psychiatric providers to establish an alignment to supplement the insufficient referral network currently available. Initial work will occur in demonstration year (DY) 11 and continue in DY12.
- b. *Clinical Pathways:* A work group will develop/adopt and implement standard screening tools to be used in the ED and ambulatory care settings. They will also develop evidenced based care plans which should improve patient care outcomes. The work group will begin this work in DY11 and continue into DY12.
- c. *Care Team Training:* MH will provide education across the care teams (e.g., provider, care coordinator, care navigator, etc.) regarding screening tools, care plans, referrals, as well as patient self-management. We will train providers and staff on each of these elements. We expect to begin this work in DY11 and have the majority completed in DY12.

We will report infrastructure/process measures for DY11 and the first reporting period of 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 is all Mono County Medicaid enrollees accessing primary care services in our clinics. For depression, and substance abuse screenings, the target population will include all our adult patients and pediatric patients (over 11). For tobacco screening we will focus on all adult patients. We intend to begin this work in one care setting (e.g., Primary Care) and then move to other setting(s) (e.g., ED and other specialty clinics). The majority of the patients will be treated by their MH primary care providers but those with more acute diagnoses or unresponsive to treatments may require a higher level referral.

Vision for Care Delivery: PRIME will enable Mammoth Hospital 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 evidenced based care plans will support providers and staff with the tools to better meet all aspects of their patients' needs. Identifying additional BMH resources will help us connect our patients to care and

services beyond the four walls of our health system. Coordinating both internal and external resources for referrals while providing training to the care team related to the importance of behavioral mental health care outcomes is an important component to improving the overall health of the patients.

3. ***For DMPHs only (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.

Project 1.1, the integration of physical and behavioral health will require Mammoth Hospital to develop infrastructure and implement proposed process measures. See Appendix.

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)

Check, if applicable	Description of Core Components
Applicable	<p>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 patients. 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.</p>
Applicable	<p>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).</p>
Not Applicable	<p>1.1.5 Patient-Centered Medical Home (PCMH) and behavioral health providers will:</p> <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	<p>1.1.6 Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families.</p>
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>

Check, if applicable	Description of Core Components
Not Applicable	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.
Applicable	1.1.10 Ensure the development of a single treatment plan that includes the patient's behavioral health issues, medical issues, substance abuse, social and cultural and linguistic needs. This includes incorporating traditional medical interventions, as well as non-traditional interventions such as gym memberships, nutrition monitoring, healthy lifestyle coaching, or access to culturally and linguistically appropriate peer-led wellness and symptom management groups.
Applicable	1.1.11 Ensure a culturally and linguistically appropriate treatment plan by assigning peer providers or other frontline worker to the care team to assist with care navigation, treatment plan development and adherence.
Applicable	1.1.12 Ensure that the treatment plan: <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.
Not Applicable	1.1.13 Implement technology enabled data systems to support pre-visit planning, point of care delivery, care plan development, population/panel management activities, coordination and patient engagement. Develop programs to implement telehealth, eReferral/eConsult to enhance access to behavioral health services.
Applicable	1.1.14 Demonstrate patient engagement in the design and implementation of the project.
Applicable	1.1.15 Increase team engagement by: <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.

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

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

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]

Rationale: MH selected this project based on the significant need for chronic non-malignant pain management services, as we currently lack the infrastructure and processes in order to improve the outcomes of the patients with these diagnoses. MC residents suffer from chronic pain conditions due to the many outdoors activities and harsh winter conditions. In 2015 MH treated approximately 2,665 MC residents for chronic pain – approximately 19% of the population. Of those total patients 426 (16%) are Medicaid. Because of the prevalence of chronic pain in our county/community and the lack of infrastructure to treat for improved outcomes, many individuals have become dependent on pain medications. As a result, improving management of these conditions through developing standard assessment tools and educating our providers on

evidence based treatment protocols should improve overall health outcomes of these patients and reduce the amount of opioid prescriptions dispensed.

Planned Design and Implementation Approach:

- a. *Care Protocols:* A work group will identify the current chronic non-malignant pain care protocols being used across all segments of MH. Adopt evidenced based standard assessment tools and multi-modal care protocols to identify these patients and improve their outcomes (DY 11-12).
- b. *Care Team Training:* MH will assess the level of education across the care team (e.g., provider, care coordinator, care navigator, etc.) regarding screening tools and protocols. We will develop training programs designed to address each of these elements. We expect to begin this work in DY11 and have the majority completed in DY12.
- c. *Reassess Current Patients:* Identify all current MC Medi-Cal patients diagnosed with chronic non-malignant pain and/or opioid dependency and reevaluate gaps in care plans based on new care protocols. Develop a plan to insert the new care protocols into their care (DY12).

We will report process measures for DY11 and the first reporting period of 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 is all Mono County Medicaid enrollees with diagnoses of chronic non-malignant pain and/or opioid dependency. Providers will be trained on the appropriate ICD-10 codes to use to better identify this target patient type. The new protocols will be infused into the existing chronic pain patients' care and the provider will evaluate the current pain medication therapy and adjust to follow the safe prescribing policy.

Vision for Care Delivery: MH will create standard chronic pain care protocols which will improve our ability to support patients suffering from chronic non-malignant pain and reduce the patient's dependency on opioid medications. Internal and external multi-model therapy resources will be established to assist the primary care providers' care for these patients. Patients will be actively involved in their care and held accountable to appropriate pain medication therapy adherence. Providers will follow the adopted safe prescribing policy to reduce the number of opioid dependent patients. If opioid medication therapy is determined ineffective providers will taper patients' dosages using the safe prescribing policy, as developed. Other non-opioid medications will be used to reduce the number of opioid dependent individuals.

3. ***For DMPHs only (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.

Project 2.6, chronic pain management will require Mammoth Hospital to develop infrastructure and implement proposed process measures. See attached.

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

Check, if applicable	Description of Core Components
Applicable	2.6.1 Develop an enterprise-wide chronic non-malignant pain management strategy.
Applicable	2.6.2 Demonstrate engagement of patients in the design and implementation of the project.
Applicable	2.6.3 Implement or adapt a state or nationally recognized methodology for the assessment and management of chronic pain.
Applicable	2.6.4 Implement protocols for primary care management of patients with chronic pain including: <ul style="list-style-type: none"> • 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.

Check, if applicable	Description of Core Components
Applicable	2.6.6 Coordinate a chronic pain care team that minimally consists of a physician champion and medical support staff. Suggestions for care clinicians from other disciplines include occupational and physical therapy, behavioral health, pharmacy, substance use disorder specialists, neurology, occupational medicine, anesthesiology/pain management, home care, social work, and physical medicine and rehabilitation.
Not Applicable	2.6.7 Implement technology-enabled data systems to support pre-visit planning, point of care delivery, and team based population/panel management and care coordination.
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.
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.

Check, if applicable	Description of Core Components
Applicable	2.6.16 Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. Timely, relevant and actionable data is used to support patient.

Please complete the summary table below:

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

Section 5: Project Metrics and Reporting Requirements

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

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

DPHs are required to strengthen data and information sharing with MCPs under the PRIME. To support this requirement, DHCS will establish data and information sharing guidelines and/or mechanisms, which DPHs and DMPHs must follow, consistent with

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

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 \$ 2,320,000
- DY 12 \$ 2,320,000
- DY 13 \$ 2,320,000
- DY 14 \$ 2,088,000
- DY 15 \$ 1,774,800

Total 5-year prime plan incentive amount: \$ 10,822,800

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.	Analysis complete of Mono County patients with: <ul style="list-style-type: none"> • BMH diagnosis • Chronic pain diagnosis 	<ul style="list-style-type: none"> • Pull data on all Mono County BMH and chronic pain diagnosis and identify the most frequent diagnosis's 	1.1, 2.6	January 1, 2016 – June 30, 2016
2.	Project team members selected	<ul style="list-style-type: none"> • Identify project team members • Identify a patient representative to help with the project 	1.1, 2.6	January 1, 2016 – June 30, 2016
3.	<ul style="list-style-type: none"> • Workforce Gap analysis completed • Employed staff • RN Care Coordinator role defined 	<ul style="list-style-type: none"> • Conduct a workforce gap analysis • ID resources needed & hire LCSW, RN Care Coordinator and Project Manager • Develop role of RN Care Coordinator 	1.1, 2.6	January 1, 2016 – June 30, 2016
4.	Behavioral health integration assessment tool selected	<ul style="list-style-type: none"> • Select a behavioral health integration assessment tool 	1.1	January 1, 2016 – June 30, 2016
5.	Chronic non-malignant pain management strategy for all of MH developed	<ul style="list-style-type: none"> • Develop a MH chronic non-malignant pain management strategy 	2.6	January 1, 2016 – June 30, 2016
6.	Nationally recognized care models selected	<ul style="list-style-type: none"> • Project teams to analyze and select one of the nationally-recognized care model for each project 	1.1, 2.6	January 1, 2016 – June 30, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
7.	Completed GAP analysis of selected care models to MH current care protocols	<ul style="list-style-type: none"> • Perform a gap analysis of the selected care model to MH current care protocols 	1.1, 2.6	January 1, 2016 – June 30, 2016
8.	Assessment tools developed/selected and protocols/ processes established	<ul style="list-style-type: none"> • Develop/select patient assessment tools and protocols for use • Develop process for “warm hand-off” when screenings are positive 	1.1, 2.6	January 1, 2016 – June 30, 2016
9.	Standard tools for treatment of chronic pain patients have been developed & adopted to implement best practices in chronic pain management.	<ul style="list-style-type: none"> • Develop Chronic Pain Agreement and protocols • Complete an inventory of providers registered with CURES and who needs training on how to use • Train and register all appropriate providers on use of CURES, including all pain medication prescribing providers • Develop & adopt policy on safe prescribing practices for pain medication including acceptable dosing and tapering methods • Research and document chronic nonmalignant pain categories to develop multi-modal treatment protocols • Complete provider and staff education on ICD-10 codes to be used for chronic nonmalignant pain diagnoses 	2.6	January 1, 2016 – June 30, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
10.	Psychiatric services affiliates identified and initial discussions of expanded BMH services completed	<ul style="list-style-type: none"> Identify potential affiliated parties to expand psychiatric services at MH Facilitate initial discussion for psychiatric services at MH 	1.1, 2.6	January 1, 2016 – June 30, 2016
11.	RN Care Coordinator education identified and training complete	<p>Training for RN Care Coordinator</p> <ul style="list-style-type: none"> Research, identify, & select education resources for RN Care Coordinator Education will be Chronic disease self-management based RN Care Coordinator to complete initial education 	1.1, 2.6	July 1, 2016 – December 31, 2016
12.	Provider and staff training for patient screening assessment and other treatment tools completed	<ul style="list-style-type: none"> Train providers and staff on the standard screening assessment and other tools (as in #8 & #9 above) for implementation 	1.1, 2.6	July 1, 2016– December 31, 2016
13.	1 st level multi-modal treatment protocols/algorithms for the chronic pain categories established.	<ul style="list-style-type: none"> Using evidenced based standards, develop and adopt standard 1st level multi-modal treatment protocols/algorithms for the chronic pain categories. 	2.6	July 1, 2016– December 31, 2016
14.	Mono County Medi-Cal patient registries created for BMH & Chronic Pain diagnoses	<ul style="list-style-type: none"> Identify Mono County Medi-Cal patients who have been diagnosed with BMH & Chronic Pain diagnoses and create patient registries for care coordination activities. 	1.1, 2.6	July 1, 2016– December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
15.	System and/or manual processes for capturing metric data implemented	<ul style="list-style-type: none"> • Develop system and/or manual methods to capture data for reporting metrics • Implement processes for capturing metric data 	1.1, 2.6	July 1, 2016– December 31, 2016