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

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

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General Instructions

Thank you for your interest in the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program. Your response to this 5-Year PRIME Project Plan ("Plan") will enable the Department of Health Care Services (DHCS) to assess if your entity can meet the requirements specified in the waiver Special Terms and Conditions (STCs) and has the capacity to successfully participate in the PRIME program.

This 5-Year PRIME Project Plan is divided into 10 sections which are structured around the Medi-Cal 2020 Waiver's Special Terms and Conditions (STCs). Additional information about the PRIME program requirements can be found in the PRIME Projects and Metrics Protocol (Attachment Q) and Funding Mechanics (Attachment II) of the STCs.

Scoring

This Plan will be scored on a "Pass/Fail" basis. The state will evaluate the responses to each section and determine if the response is sufficient to demonstrate that the applicant will be able to effectively implement the selected PRIME Projects while simultaneously conducting the regular business of operating the hospital system.

In the event that a response to a Plan section is not sufficient and fails to meet review criteria, the applicant will have an opportunity to revise the response(s) to meet the state's satisfaction. Applicants will have three (3) days to complete the revisions upon receiving feedback from the state.

Please complete all sections in this 5-Year PRIME Project Plan, including the Appendix (the infrastructure-building process measure plan as applicable), and return to Tianna Morgan at PRIME@dhcs.ca.gov **no later than 5:00 p.m. on April 4, 2016**.

Section 1: PRIME Participating Entity Information

Health Care System/ Hospital Name	Contra Costa Regional Medical Center, Health Centers and Detention Health (CCRMC and HCs)
Health Care System Designation (DPH or DMPH)	DPH

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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.

Contra Costa Regional Medical Center, Health Centers and Detention Health (CCRMC and HCs) is based in Martinez, Calif., with 11 ambulatory health centers. Contra Costa County is experiencing rapid population growth and rising poverty. Many patients face food and housing insecurity and transportation issues as they struggle to earn living wages. These daily stressors are showing up in poor health among our population served.

Physical Health. The leading causes of death are cancer, heart disease and stroke. Diabetes, obesity, hypertension and asthma are the most common chronic health conditions and contribute to poor quality of life.
_*Cancer.* We have a higher proportion of late-stage cancer diagnoses. In 2014, 27% of women newly diagnosed with breast cancer at our health system had localized disease, compared to the national benchmark of 62.6%. Late-stage colon cancer diagnoses were higher at our health system than the average of 30 other community hospitals in California (48% vs. 40% of stage III and IV colon cancer at diagnosis). The most common cancer deaths are lung, colorectal, breast and pancreatic.
_*Heart Disease.* Heart disease is the leading cause of death after all cancers, accounting for 22.7% of all deaths in the county.
_*Diabetes/Obesity.* The percentage of pediatric patients with a BMI of 85th percentile or more treated in our health system was about 44% in DY10. About 8% of adults in our county have diabetes, while another 47% are pre-diabetic (compared to statewide incidence of 9% and 46%, respectively). About 24% of adults are obese and 39% are overweight (on par with state averages of 25% and 35%, respectively).
_*Asthma.* Some 19% of children ages 1 to 14 have an asthma diagnosis in our county, compared to 13.8% statewide.

Behavioral Health In 2015, nearly one-third of primary care patients screened for mental health at our health centers had a depression diagnosis (7,336/25,540). Nearly one in five patients screened had an alcohol problem (4,555/25,431). We have identified substance abuse as a "condition of vulnerability." In one study, 38% of hospitalized patients were diagnosed with a substance abuse problem and those patients were almost twice as likely to have one or more readmissions compared to peers without a substance abuse diagnosis.

Health Disparities. African American residents have a life expectancy seven years shorter than white residents (74 vs. 81 years old). African Americans are more likely to die from heart disease and cancer than white, Hispanic or Asian residents.
Coverage. Our county has about 267,000 Medi-Cal beneficiaries. Our health system serves 90% of all Medi-Cal patients in the county. Nearly 20,000 county residents are Medi-Cal eligible but not enrolled.

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.

Contra Costa County is a mix of urban, suburban and rural communities in the San Francisco Bay Area. Our county of 1.1 million people is one of the largest census tracts in the nation, and is nearly the size of Rhode Island. Our population grew 6% over the past five years and demographics are changing rapidly with the rising cost of living and growing poverty.

Income. Residents living below federal poverty level rose from 7.3% in 1990 to 10.8% in 2013. In the east county city of Bay Point, adjacent to Martinez, the poverty rate is 28.3%, an increase of 46.6% over five years. The average per capita income countywide is $38,700. The percent of owner-occupied housing fell from 70.7% in 2005-2009 to 65% in 2010-2014.

Self-sufficiency. Wages necessary for a family of four to live in our county increased by 10% in 2014 over the prior year.

Race/Ethnicity and Language. The population is 46% White; 25% Latino; 17% Asian; 10% African American; 1% Native American/Alaska Native; and 0.6% Native Hawaiian/Pacific Islander. Among residents five years and older, 33.5% said they spoke a language other than English at home. Of those, 55% said they spoke Spanish at home, 28% spoke an Asian or Pacific Islander language and 17% spoke another Indo-European language. About 40% said they did not speak English "very well." In 2011, 23% of residents in our county said they were foreign born.

Age:
0-18 years (29%)
19-64 years (57%)
65 and over (14%)

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.

CCRMC and HCs is a general acute care county public hospital with a network of 11 ambulatory health centers located across the county. We provide acute inpatient medical and surgical care, emergency services and inpatient acute psychiatric services and psychiatric emergency services. We have 167 licensed beds, including 78 medical/surgical; 11 perinatal; 21 postpartum; 8 critical care; 6 intensive care newborn nursery; and 43 acute psychiatric beds.

Care is available 24 hours per day, seven days per week at our inpatient hospital and Level II emergency department in Martinez, Calif. We are the county's evaluation center for patients on involuntary psychiatric hold.

In 2015, we had a total of 49,460 patient days and 10,581 patient discharges. We had 423,438 outpatient visits; 45,299 ED visits; and 10,160 psychiatric emergency visits. The average length of stay was 4.7 days. Staffed hospital beds had an occupancy rate of 85.5%. Staffed beds as a percentage of licensed beds was 88%.

Our payer mix is 21% Medicare, 42% Medi-Cal, 30% managed care and 7% other. Our programs have received national and state recognition. In 2015, accolades included an Outstanding Achievement Award in 2015 from the American College of Surgeons' Commission on Cancer; a 2015 CAPH/SNI Quality Leaders/Kaiser Permanente Clinical Systems' Development Award for our Advanced Access Bundle; and recognition for performance excellence by the Collaborative Alliance for Nursing Outcomes (CALNOC).

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.

Since implementing an electronic health records (EHR) system in 2012, we have made progress towards a robust, integrated system to capture, analyze and distribute performance data.

Data Collection. We continue to invest in disease registries to support population health management. We have registries for asthma, diabetes, hypertension and HIV, and will roll out a depression registry in DY11. We view whole person care databases and disease registries as important tools to achieve our aim of total community health. We

are consolidating legacy data systems, claims, case management and behavioral health data into our data warehouse to break down data silos and tell a more complete story of population health.

Reporting. Our PRIME matrix dashboard will be rolled out in DY11 and will be accessible to team members. A major focus in our reporting efforts is to invest in self-service analytics. This means that teams can interrogate the data themselves for targeted improvement efforts without requiring a report writer. Not only will this make data more accessible and flexible for team members, it will require fewer resources from our analytics team.

Monitoring. Each PRIME project team has an assigned metrics steward who collects project data is responsible for data integrity. A Data Governance Committee and the PRIME Steering Committee meet weekly to review the data. We have instituted regular data quality checks and have updated workflows to ensure data accuracy.

A challenge we face is matching workflows to the data. To address this, we will make data capture more seamless with clinical work; standardize workflows so that the data we capture is complete and relevant; and document that the data has been captured so that we can identify and remove barriers to data capture.

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.*

As an organization, we strive to create optimal health for all through respectful relationships and high quality service. Our goals to achieve optimal community health include:

- Being patient and family centered
- Fostering continuous improvement
- Delivering value and safe care

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.*

Our specific aims for PRIME participation are:

- *Expanding access*. To deliver patient- and family-centered care and value, we will identify and implement lasting changes such as reducing wait times and delays and providing greater continuity of care. Specifically, these changes include applying innovations to facilitate specialty care referrals; reorganizing primary care teams to maximize efficiencies; spreading multidisciplinary high-touch interventions for high-risk patients with complex care needs; and identifying and removing barriers to outpatient visits for post-acute, foster child and perinatal

patients.

- *Integrating physical and behavioral health*. Behavioral health integration is an important aim for us to deliver patient- and family-centered care. To achieve this aim we will spread and sustain screening tools for depression and substance abuse, with interdisciplinary care teams coordinating services.
- *Improving population health and reducing disparities.* Fostering continuous improvement and delivering value require a total population health management approach. We will remove barriers to cancer screenings with access innovations. Care teams will incorporate disease registries into workflow for improved population health management and to reduce disparities.
- *Providing evidence-based care.* We will deliver value and safe care and foster continuous improvement by educating providers and patients on evidence-based best practices in high-cost imaging and non-malignant pain management.

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;*

We selected 10 projects for PRIME participation. All 10 projects directly correspond to our organizational goals and specific aims and provide us with a means to measure our progress.

We are experiencing tremendous growth in both county population and in the newly insured. Enrollment in Contra Costa Health Plan grew from 88,000 members in 2010 to 185,000 members in 2015. The health plan covers about 75% of patients seen at our health clinics, and we are partners on care improvement initiatives. PRIME will help us deliver appropriate, patient-centered care within this context of expanded population served.

All PRIME projects are at their core about compassion, respect, innovation and partnerships. These are values that we hold dear and are key to achieving optimal health in our county.

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*

The proposed projects interrelate in important ways to achieve system transformation. Screening primary care patients for depression and substance abuse will allow us to deliver appropriate care to all patients in a medical home model. Our primary care system, carefully managing population health, will collaborate with specialty care and

preventative screening teams to make sure patients are getting the services they need in a timely manner. Educating patients and providers about appropriate imaging and pain-management medications helps create a culture of patients as partners, improve safety and deliver value. Identifying high-risk patients with complex care needs and smoothing care transitions improves coordination between acute and ambulatory settings and can reduce avoidable readmissions and ER visits.

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.*

Our vision at the end of five years is to be a center for health excellence that delivers the right care to patients in a timely manner and in a location they prefer. We envision an intuitive system of care where patients are guided through clinical pathways that are determined by their needs in partnership with provider teams. We aim to provide a seamless experience to our patients, while supporting staff and providers in their work delivering superior care to our community members. Our infrastructure development will support improved care across the continuum, from preventative services to acute care episodes. A robust clinical capacity and infrastructure aims to reduce avoidable ED visits, hospitalizations and readmissions.

3.2 Meeting Community Needs. [No more than 250 words]

Describe how your organization will address health needs at a local level as described in Section 2 of the Plan. The narrative should clearly link the projects you select in Section 4 with the community needs identified in your response to Section 2.1.

Our community members face myriad chronic health conditions that are made worse by the growing poverty rate and ongoing health disparities in our service area. We recognize that past efforts to address these problems through acute-based, silo care systems were ineffective. All 10 of our PRIME projects support our continued work to remove barriers and deliver more responsive, collaborative and integrated care.

We are well positioned to achieve our goals because of the enduring infrastructure we built during the DSRIP. Having a total picture of patient health and offering access and interventions where appropriate, using evidence-based methods, we can begin to influence some of our most problematic disease states as described in Section 2.1.

Our focus is on patient-centered care as a primary strategy. Our infrastructure – both physical and technological – must literally break down walls. In each project, we are mindful to make sure the changes we make are culturally sensitive, enhance the patient experience and reduce health disparities.

We anticipate that better population health management, earlier interventions and improved access to primary care integrated with behavioral health will reduce avoidable ED visits and readmissions.

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).

In 2015, we unveiled a five-year strategic plan. The strategic plan is the foundation for all our initiatives that will be undertaken through 2020, and all projects are in service of the strategic plan. As described in Section 3.1, the strategic plan is a roadmap for creating optimal health for all.

In January 2016, we formed a PRIME Steering Committee to begin planning and participation in the new program. This committee previously provided primary oversight to our DSRIP program and includes our executive team, business intelligence and

quality leaders. The PRIME Steering Committee guides development of the PRIME plan; recommends strategies for implementing PRIME to the project teams; oversees resource allocation; and monitors progress towards meeting PRIME goals and performance standards. The PRIME Steering Committee meets weekly.

Additionally, our Improvement Academy is a weekly forum that offers opportunities for cross-collaboration and shared learning among PRIME team members. We expect this group to meet at various locations throughout the county for maximum participation. Our PRIME Steering Committee and PRIME teams will have access to a self-servicing dashboard to track metric progress.

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.

We involve our clinicians, staff, patients and families and community partners – our "brain trust" – in developing priorities and implementing plans, including PRIME. Our PRIME Steering Committee includes representatives from across our organization to make sure we are hitting all angles of the projects and that projects are resourced appropriately. Our Improvement Academy is an opportunity for PRIME team members to engage in shared learning. We include our patient and family partners in PRIME implementation, including our behavioral health patient advocates. We periodically hold rapid improvement exercises, *kaizens,* and patient partners are important participants in these events.

As a public health system, we report out on PRIME progress to the Contra Costa County Board of Supervisors through our public Joint Conference Committee. Members of the public can provide comment at these meetings. We also provide updates on PRIME progress on our website and issue an annual report that includes patient and caregiver stories highlighting the important improvement work underway.

We count on community-based organizations and relevant county departments and agencies to be partners in PRIME. We will continue to include these stakeholders in the planning process and identify additional organizations where appropriate.

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.

Our infrastructure for delivering culturally appropriate patient services and identify and address disparities includes the following:
Interpreter Services. Each month we provide video interpretation services in at least 45 different languages for the nearly half of our patients who chose to communicate with their provider in a language other than English. Our on-staff interpreters also provide translation services for PRIME project materials as needed.

Health Education Liaisons. Our network of *promotoras* and African American health conductors are assets that we include in PRIME project planning.
REAL Data. About 92% of patients registered in our health system have accurate REAL data, which helps us design appropriate programs and interventions.

Patient Portal. More than 16,000 patients have activated their online patient portal, where they receive targeted communications, schedule appointments and contact their providers. The portal is in English and Spanish and our interpreter services team is available to translate physician-patient secure email communications.

LGBT Inclusion. The Human Rights Campaign Foundation recognized our system as a leader in healthcare equality. Our LGBT Healthcare Taskforce advises on inclusion and equalty.

Equity Team. Our Equity Team meets periodically to review data, identify disparities and develop and implement plans to reduce disparities.

3.6 Sustainability. [No more than 150 words]

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

We build capabilities by giving our staff opportunities to participate in training and leadership programs that can help them achieve their professional goals and improve our organization. These include:
Change-Agent Fellowship. A 15-month program to develop and support transformational leaders in improving quality. Fellows learn Lean methodology and Institute of Medicine Safety aims. This ongoing program has given us a deep cadre of leaders with extensive knowledge of quality improvement.

Leadership Academy. A yearlong leadership development experience. The academy includes in-person and virtual coaching with the goal of leading improvement, augmenting skills and building effective partnerships.

Improvement Academy. Our PRIME Improvement Academy, as described above, is a weekly forum for PRIME team members.

IHI Collaboration. Our ongoing collaboration with IHI includes site visits, coaching and leadership support. Currently, our focus of this collaborative is perinatal health, behavioral health integration and building and sustaining capabilities.

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)

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]

This project will build on the work we began five years ago to reorganize our care teams and infrastructure to better identify, reach and respond to our patients with behavioral health needs. By integrating physical and behavioral health, we will improve outcomes and reduce incidence of long-term chronic illnesses. Currently, seven of our 11 ambulatory care clinics have co-located primary care and behavioral health services. We intend for the following implementation plan to apply to at least eight ambulatory care clinics where possible. We will modify this plan to meet the needs of our three smallest clinics, based on size and patient volume.
Our planned implementation includes:

- *Team Organization.* Conduct a test of change of team organization by creating an Integrated Behavioral Health Team (IBH) at one site. This interdisciplinary team will have the goal of competently and effectively assessing, treating and managing patients' behavioral health needs. This work will begin in DY11.
- *Referral Processes*. Standardize processes to send and track referrals to behavioral health specialists and make sure those referrals are appropriate. Implementation of a referral processes based on patient acuity and a “no wrong door“ policy will begin in DY11.
- *Evidence-Based Practices*. We piloted and successfully implemented depression and substance abuse screenings drawing from the SBIRT tool at some health centers during the DSRIP. We will continue the full spread of SBIRT and improve compliance through support, training and oversight in DY11.
- *Technology-Enabled Interventions.* Our depression registry, expected to be online in DY11, will help teams manage patient populations. Through our EHR, we are integrating and standardizing tools for diagnostic, monitoring and outcomes with work beginning in DY12. As provider workflows change and evolve, IT will continue to support the spread of SBIRT and other screening tools to optimize adoption.

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

Target Population: As stated in section 2.1, nearly one-third of primary care patients

screened at our health centers for mental health problems had a positive depression diagnosis (7,336/25,540) in 2015. Nearly one in five patients screened at our health centers had an alcohol problem (4,555/25,431). We have identified substance abuse as a “condition of vulnerability“ in our system connected to higher readmission rates. Of the patients in our system referred for behavioral health services, 60% present in the moderate range of mental health acuity, while another 20% each present in the mild or severe range. To improve health outcomes and patient experiences, this target population requires appropriately designed clinical pathways and interventions.

Vision for Care Delivery: Integrating behavioral and physical health means more than just improving screening metrics, though that is important. It means building a consistent structure and testing and implementing innovative approaches for sustained performance improvement. This improvement is measured by the overall health and wellbeing of our community, both mentally and physically. A culture of continuous improvement is well positioned to fully address the complete health needs of patients and their families at all points of interaction.

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

Check, if applicable	Description of Core Components
Applicable	**1.1.5** Patient-Centered Medical Home (PCMH) and behavioral health providers will: • Collaborate on evidence based standards of care including medication management and care engagement processes. • Implement case conferences/consults on patients with complex needs.
Applicable	**1.1.6** Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families.
Applicable	**1.1.7** Ensure systems are in place to support patient linkages to appropriate specialty physical, mental and SUD services. Preventive care screenings, including behavioral health screenings (e.g., PHQ-2, PHQ-9, SBIRT), will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including the provision of brief interventions (e.g., motivational interviewing techniques) to ensure access for further evaluation and treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.
Applicable	**1.1.8** Provide cross-systems training to ensure effective engagement with patients with MH/SUD conditions. Ensure that a sufficient number of providers are trained in SBIRT and/or in other new tools used by providers to ensure effectiveness of treatment.
Applicable	**1.1.9** Increase access to Medication Assisted Treatment (MAT) for patients with alcohol and opioid addiction to assist in stabilizing their lives, reducing urges or cravings to use, and encourage greater adherence to treatment for co-morbid medical and behavioral health conditions. For alcohol use disorders these medications include naltrexone, acamprosate, and disulfiram. For opioid addiction, medication assisted treatment (MAT) includes maintenance treatment with methadone and buprenorphine.
Not Applicable	**1.1.10** Ensure the development of a single treatment plan that includes the patient's behavioral health issues, medical issues, substance abuse, social and cultural and linguistic needs. This includes incorporating traditional medical interventions, as well as non-traditional interventions such as gym memberships, nutrition monitoring, healthy lifestyle coaching, or access to culturally and linguistically appropriate peer-led wellness and symptom management groups.

Check, if applicable	Description of Core Components
Not Applicable	**1.1.11** Ensure a culturally and linguistically appropriate treatment plan by assigning peer providers or other frontline worker to the care team to assist with care navigation, treatment plan development and adherence.
Not Applicable	**1.1.12** Ensure that the treatment plan: • Is maintained in a single shared Electronic Health Record (EHR)/ clinical record that is accessible across the treatment team to ensure coordination of care planning. • Outcomes are evaluated and monitored for quality and safety for each patient.
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: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on care model.
Applicable	**1.1.16** Ensure integration is efficient and providing value to patients by implementing a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

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

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]

We recognize that we must continue to improve our primary care system to meet our current and future projected demand for services. Over the past five years, we have worked to implement Patient-Centered Health Homes (PCHHs) at our ambulatory care centers to deliver the right care at the right time in a location patients prefer. Over the next five years we will continue to improve PCHHs. A major focus will be on spreading improvements under a variety of conditions at different sites, and then making those improvements standard practice and embedded in daily workflows. Our planned implementation approach includes:

- *Care Team Training.* We will continue reorganizing clinician duties and conducting trainings so all team members are performing at the top of their credential. At the same time, we will expand teams to include frontline workers who coordinate non-clinical services. This work will begin in DY11.
- *Criteria Selection*. We continue to add disease registries to our system, and will develop care interventions around those registries. Our current registries applicable to this project are: diabetes, hypertension and depression. Interdisciplinary teams will establish criteria for patient inclusion using nationally recognized methodologies and conduct tests of change at a pilot site.
- *Care Coordination.* We will conduct an assessment on opportunities for care coordination and assign coordinators to high-risk patients and their care teams. This work will be done in conjunction with behavioral health integration, specialty care coordination and care management for high-risk patients.
- *Care Innovations.* We will identify opportunities for alternative care access models such as our Telephone Consultation Clinic, which provides telephone visits with physicians to pre-screened patients.

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

Target Population. Our target population is our adult and pediatric patients. In 2015, we averaged more than 15,000 health center visits per month. We expect that number to grow. Our system has more than 108,000 empaneled patients, and family medicine providers had an average patient panel size of nearly 1,700 in 2015.

Vision for Care Delivery. Continuing our implementation of Patient Centered Health Homes will allow us to meet the health needs of our growing population and also develop tools to anticipate healthcare needs. Population health management allows us to move upstream to care for patients before they become acutely ill. Disease registries, screenings as well as programs that keep chronic health conditions in check can help us realize our vision of moving from a sick-based to a well-based model of care delivery.

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

Check, if applicable	Description of Core Components
Not Applicable	**1.2.1** Conduct a gap analysis of practice sites within the DPH/DMPH system.
Applicable	**1.2.2** Primary care practices will demonstrate advancement of their PCMH transformation through the use of a nationally-recognized PCMH methodology.
Applicable	**1.2.3** Hiring and training of frontline workforce (e.g., medical assistants, community health workers, promotoras, health navigators or other non-licensed members of the care team) to be responsible for coordination of non-clinical services and elements of the care plan.
Applicable	**1.2.4** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population/panel management activities, care coordination, patient engagement, and operational and strategic decisions including a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. • Implementation of EHR technology that meets meaningful use (MU) standards.

Check, if applicable	Description of Core Components
Applicable	**1.2.5** Ongoing identification of all patients for population management (including assigned managed care lives): • Manage panel size, assignments, and continuity to internal targets. • Develop interventions for targeted patients by condition, risk, and self-management status. • Perform preventive care services including mental health and substance misuse screenings and brief interventions (e.g., PHQ-9, SBIRT).
Applicable	**1.2.6** Enable prompt access to care by: • Implementing open or advanced access scheduling. • Creating alternatives to face-to-face provider/patient visits. Assigning frontline workers to assist with care navigation and non-clinical elements of the care plan.
Applicable	**1.2.7** Coordinate care across settings: • Identification of care coordinators at each primary care site who are responsible for coordinating care within the PCMH as well as with other facilities (e.g., other care coordinators or PCMH/DPH/DMPH high risk care managers): o Establish onsite care/case managers to work with high risk patients and their care teams, or develop processes for local care coordinators to work with a central complex care management program for these patients Implement processes for timely bi-directional communication and referral to specialty care (including mental health and substance use disorder services), acute care, social services and community-based services.
Applicable	**1.2.8** Demonstrate evidence-based preventive and chronic disease management.
Applicable	**1.2.9** Improve staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the team-based care model to ensure effective and efficient provision of services (e.g., group visits, medication reconciliation, motivational interviewing, cognitive behavioral therapy and Medication-Assistance Treatment (MAT)).

Check, if applicable	Description of Core Components
Not Applicable	**1.2.10** Engage patients using care plans, and self-management education, and through involvement in the design and implementation of this project.
Not Applicable	**1.2.11** Improve the accuracy and completeness of race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI) data, and use that data to identify and reduce disparities in one or more Primary Care Redesign project metrics by: • Adding granular REAL and SO/GI data to demographic data collection processes and training front-line/registration staff to gather complete and accurate REAL/SO/GI data. • Developing capacity to track and report REAL/SO/GI data, and data field completeness. • Implementing and/or refining processes for ongoing validation of REAL/SO/GI data. • Developing capacity to stratify performance metrics by REAL/SO/GI data and use stratified performance data to identify disparities for targeted interventions. • Developing capacity to plan and implement disparity reduction interventions with input from patients and community stakeholders. • Developing dashboards to share stratified performance measures with front-line staff, providers, and senior leadership.
Applicable	**1.2.12** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

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

With the tremendous growth in Medi-Cal and in the Contra Costa Health Plan membership as described in Section 3.1, we have experienced a huge influx of patients to our system. Improving appropriate access to specialty care can enhance care coordination and the patient care experience. Our planned implementation approach includes:

- *Gap and Needs Assessment*. Conduct an assessment of specialty care patient needs and gaps in care, including wait times for appointments with specialists. This work will begin in DY11.
- *eConsult Implementation.* We received a $100,000 grant from the Blue Shield of California Foundation to implement eConsult, an electronic consultation and referral tool for providers and specialists. This implementation planning will begin in DY11.
- *Workflow Standardization.* Develop and implement workflow standards for referrals, in concert with eConsult implementation.
- *Physician Champions.* Identify and deploy physician champions to educate specialists about improvements to referral processes. This work will start in DY11.
- *Language Standardization.* Improve communication used by specialists to convey referrals and to relay that a referral loop has closed.
- *Care Innovations.* Identify opportunities for alternative care access models, including telehealth expansion (beyond eConsult). We currently have telehealth services for psychiatry and neurology and are actively exploring implementing a telederm program.

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

Target Population. Our health system has about 150,000 specialty visits each year. Wait times to see specialists vary greatly. The median wait time to see a podiatrist for a routine appointment in 2015 was 117 days, while an urgent podiatry appointment had a median wait time of eight days, for instance. ENT specialists had wait times of over 100 days for routine appointments, and around 10 days for urgent appointments. The overall median for all specialists for routine appointments was 43 days; for urgent appointments the median wait time was 14 days.

Vision for Care Delivery. Appropriate and timely access to specialty care is an important aspect of implementing Patient-Centered Health Homes. We envision a system where primary care providers coordinate with specialists on care decisions, with a closed feedback loop to ensure each patient's needs are met. Wait times to see specialists will be minimal thanks to more appropriate referrals and innovations in care appointments. Reducing specialty care wait times will reduce ED visits and improve patient outcomes and the patient experience.

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

Check, if applicable	Description of Core Components
Not Applicable	**1.3.1** Develop a specialty care program that is broadly applied to the entire target population.
Not Applicable	**1.3.2** Conduct a gap analysis to assess need for specialty care including mental health and SUD services (analysis to include factors impacting ability to access specialty care), and the current and ideal state capacity to meet that need. Benchmark to other CA Public Health Care systems.
Not Applicable	**1.3.3** For ideal state analysis, include potential impact of increased primary care capacity to manage higher acuity conditions either independently, or in collaboration with, specialty care, so as to reduce the need for in-person specialty care encounters (e.g., insulin titration, IBS management, joint injections, cognitive behavioral therapy (CBT) or MAT).
Not Applicable	**1.3.4** Engage primary care providers and local public health departments in development and implementation of specialty care model.

Check, if applicable	Description of Core Components
Not Applicable	**1.3.5** Implement processes for primary care/specialty care co-management of patient care.
Not Applicable	**1.3.6** Establish processes to enable timely follow up for specialty expertise requests.
Not Applicable	**1.3.7** Develop closed loop processes to ensure all requests are addressed and if in person visits are performed, that the outcome is communicated back to the PCP.
Not Applicable	**1.3.8** Ensure that clinical teams engage in team- and evidence-based care.
Applicable	**1.3.9** Increase staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the care model.
Applicable	**1.3.10** Develop and implement standardized workflows for diversified care delivery strategies (e.g., shared medical visits, ancillary led services, population management, telemedicine services) to expand access and improve cost efficiency.
Not Applicable	**1.3.11** Adopt and follow treatment protocols mutually agreed upon across the delivery system.
Not Applicable	**1.3.12** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population management activities and care coordination/transitions of care. Ensure that timely, relevant, and actionable data are used to support patient engagement, PCP collaboration, and drive clinical, operational and strategic decisions including continuous quality improvement (QI) activities.
Not Applicable	**1.3.13** Implement EHR technology that meets MU standards.
Not Applicable	**1.3.14** Patients have care plans and are engaged in their care. Patients with chronic disease (including MH/SUD conditions) managed by specialty care have documented patient-driven, self-management goals reviewed at each visit.
Not Applicable	**1.3.15** Improve medication adherence.

Check, if applicable	Description of Core Components
Not Applicable	**1.3.16** Implement population management strategies for patients in need of preventive services, with chronic conditions, or with recurring long term surveillance needs.
Applicable	**1.3.17** Implement or expand use of telehealth based on DPH/DMPH capacity to address patient and PCP barriers to accessing specialty expertise. Implement a telehealth platform with communication modalities that connect between specialty care and primary care (e.g., eConsult/eReferral).
Not Applicable	**1.3.18** Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**1.3.19** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.
Not Applicable	**1.3.20** Test use of novel performance metrics for redesigned specialty care models.

☒ 1.6 – Cancer Screening and Follow-up

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]

Over the past five years, we have made strides to improve access to cancer screenings. Changes include adding walk-in and after-hours mammography clinics and coordinating educational campaigns with the Contra Costa Health Plan. However, we recognize that we have work to do to meet and surpass state and national cancer screening rates. Our patient population has a high burden of late stage and invasive cancers, as described in Section 2.1. Our patients face barriers to preventative care including lack of transportation, childcare and paid time off from work. To be successful, our cancer screening programs must fit in with the realities of our patients' daily lives.

Our planned implementation approach includes:

- *Gap Analysis Study:* Conduct an analysis of Medi-Cal cancer screening rates compared to our own rates to help understand the reasons for the gap. This analysis will entail refining and validating available reports with pertinent screening demographic data. Also identify best practices to effectively reach Medi-Cal patient population with low screening yields. This analysis will be completed in DY11.
  Access Study: Conduct an analysis of screening programs, access points and roadblocks to access. Evaluate systemic barriers including telephone access, EHR design, and parking issues. Staff structure and ratios to meet patient volume needs and to optimize outreach and implementation of screening protocol will also be assessed.
- *Collaboration:* Review best practices adopted by other systems in the Bay Area and the state to find and adopt strategies that work for our system.
- *Committee Formation.* Convene a Cancer Screening Committee, including a radiology manager, primary care physician, nurse practitioner, head of gastroenterology, mammography lead and cancer care surgeons.
- *Data Capture Strategy.* Conduct a thorough review of data capture and the authenticity of data already collected. Because many colonoscopies are done with contracted providers outside our EHR system, we will create a strategy to make sure we are tracking screenings and following up with positive cancers.
- *Test Bundle.* Conduct a pilot of the colorectal screening FIT test bundle. We plan to use a Kaiser Permanente protocol of bundling the FIT test with influenza immunization clinics. This work will start in DY11.

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

Target Population: Our target population is all patients eligible for recommended screenings for breast, colon and cervical cancers. We are still developing baseline numbers for these populations.

Vision for Care Delivery: Cancer screening is one of the most important value propositions we can deliver to our patients. We will determine who in our community has unmet screening needs, what the barriers are and how to remove them. Our vision is that every member of our community eligible for cancer screening receives that screening in a timely manner and those results are tracked over time. Being the healthiest community in the nation requires a dynamic and effective cancer-screening program.

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

Check, if applicable	Description of Core Components
Applicable	**1.6.1** Develop a multi-disciplinary cross-participating PRIME entity task force to identify principle-based expected practices for screening and follow-up for the targeted services including, but not limited to: • Standard approach to screening and follow-up within each DPH/DMPH. • Screening: o Enterprise-wide standard approach to screening (e.g., ages, frequency, diagnostic tool). • Follow-up for abnormal screening exams: o Clinical risk-stratified screening process (e.g., family history, red flags). Timeliness (specific time benchmark for time from abnormal screening exam to diagnostic exam).
Not Applicable	**1.6.2** Demonstrate patient engagement in the design and implementation of programs.
Applicable	**1.6.3** Collect or use preexisting baseline data on receipt and use of targeted preventive services, including any associated disparities related to race, ethnicity or language need.
Applicable	**1.6.4** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to USPSTF A and B Recommendations.
Applicable	**1.6.5** Improve access to quality care and decrease disparities in the delivery of preventive services.
Not Applicable	**1.6.6** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
Applicable	**1.6.7** Adopt and use certified electronic health record systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population management approaches (e.g., in-reach, outreach) to reduce gaps in receipt of care.
Applicable	**1.6.8** Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and

Check, if applicable	Description of Core Components
	connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.
Applicable	**1.6.9** Implement a system for continual performance management and rapid cycle improvement that includes feedback from patients, community partners, front line staff, and senior leadership.

Please complete the summary chart:

	For DPHs	For DMPHs
Domain 1 Subtotal # of DPH-Required Projects:	**3**	
Domain 1 Subtotal # of Optional Projects (Select At Least 1):	**1**	
Domain 1 Total # of Projects:	**4**	

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

☒ 2.1 – Improved Perinatal Care (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]

We are the primary labor and delivery center for Medi-Cal patients in our county, and more than 95% of deliveries at our hospital are covered by Medi-Cal. Giving babies the best possible start in life while supporting mothers and families is a priority for us as we work to achieve our vision of becoming the healthiest community in the nation. Our planned implementation approach includes:

- *Resource Assessment.* Conduct an assessment on currently available resources such as lactation consultants, staff and physician competencies, educational materials and trainings available to support prenatal care, exclusive breastfeeding and post-partum care. This work will be completed in DY11.
- *Champion Designation.* Recruit and assign key team members to educate and train frontline staff on Baby Friendly designation.
- *Patient Experience Inclusion.* Recruit and educate patient advocates, including former perinatal patients, as patient partners to help us improve the patient experience for the continuum of perinatal care. This work will begin in DY11.
- *Chart Audits.* Examine coding practices to ensure that all applicable information on deliveries, births and complications is coded correctly. This includes standardizing documentation, providing training to coders and conducting random audits to ensure accuracy. This work will begin in DY11.
- *Education.* Conduct clinician education on evidence-based practices to improve outcomes. For instance, addressing physician concerns that reducing C-section rates could result in adverse neonatal outcomes.
- *Services Coordination.* Share strategies to avoid duplication of efforts in prenatal care, discharge planning and postpartum follow up with the Contra Costa Health Plan and the PRIME Care Transitions and Ambulatory Care Redesign teams. Create opportunities for collaboration with primary care to maximize prenatal and postpartum care visits and improve visit attendance. Identify and strategize ways to remove barriers to prenatal and post-partum care.

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

Target Population: Our target population is pregnant women, new mothers and their families. As stated, we are the major birthing center for Medi-Cal enrollees in our county. This offers us an enormous opportunity to encourage healthy behaviors that can last a lifetime. More than 2,200 babies were born at our hospital in 2015.

Vision for Care Delivery: We see this project as an opportunity to continue to deliver evidence-based practices throughout perinatal care and to encourage healthy habits for our patients. Working with patients as partners can improve the care experience and health outcomes during pregnancy, birth and post-partum visits and beyond.

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

Check, if applicable	Description of Core Components
Applicable	**2.1.1** DPHs/DMPHs engagement in best practice learning collaborative to decrease maternal morbidity and mortality related to obstetrical hemorrhage (CMQCC/PSF/HQI combined effort).
Applicable	**2.1.2** Achieve baby-friendly hospital designation through supporting exclusive breastfeeding prenatally, after delivery, and for 6 months after delivery and using lactation consultants after delivery.
Not Applicable	**2.1.3** Encourage best practice and facilitate provider education to improve cesarean section rates, and decrease inequities among cesarean section rates. Participate, as appropriate, in statewide QI initiatives for first-birth low-risk cesarean births.
Not Applicable	**2.1.4** Coordinate care for women in the post-partum period with co-morbid conditions including diabetes and hypertension.

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

This project aims to provide patients and families with tools and support to manage their health after leaving the hospital. Our goals are to improve health outcomes, increase patient engagement, provide a better patient experience and reduce readmissions and complications. Our planned implementation approach includes:

- *Methodology Selection.* We conducted a pilot care transition program several

years ago with a subset of hospitalized patients identified as high risk for readmission. That pilot is no longer functioning. This PRIME program will build on investments and lessons learned from that initial pilot. In DY11 we will choose a care transition program methodology and pilot patient population.

- *Resource Identification.* We will partner with the Contra Costa Health Plan, which currently has a care transition nurse with patients at four post-acute care facilities, on this project to leverage post-acute care resources and avoid redundancies. Through this partnership we seek to optimize care for patients placed in skilled nursing facilities post-discharge.
- *Criteria Selection.* We will work with data analytics to identify hospitalized patients at high risk of readmission and target those patients for appropriate interventions, using chosen methodology. This work will begin in DY12.
- *Standard Workflows.* We will conduct an assessment of discharge communications materials to make sure that they fit into provider workflows and are appropriate for patients. We will include ambulatory care teams in planning to ensure smooth transitions from inpatient to outpatient settings and to deliver timely access to primary and/or specialty care. .
- *Medication Reconciliation.* We plan to involve pharmacy staff on medication reconciliation for patients leaving the hospital and post-discharge. However, this aspect of the project will be challenging because of a shortage of pharmacists and difficulty recruiting pharmacists.
- *Technology Interventions.* Investigate ways to leverage our EHR or other technology platforms to provide post-discharge documentation to primary care providers. Review our approach to scheduling follow up care with primary and specialty care providers for post-acute care patients.

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

Target Population. A comprehensive care transition program has the potential to improve the experience for all discharged patients. In 2015, we had a total of 10,581 discharges. A robust care transition program will affect all of our discharges, but will especially have an impact on our highest-risk individuals for re-admission. Specifically, those with advancing age, multiple co-morbid conditions, substance abuse and co-existing mental health diagnoses.

Vision for Care Delivery. Our goal is to create a seamless and positive experience for patients leaving our inpatient care. We also seek to empower patients and their families to be full partners in their care after they leave the hospital. Effective communications around discharge planning and access to timely follow-ups ensure care continuity and reduce avoidable readmissions and complications.

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

Check, if applicable	Description of Core Components
Applicable	**2.2.1** Develop a care transitions program or expand a care transitions program to additional settings (e.g., emergency department), or to additional populations, using or adapting at least one nationally recognized care transitions program methodology.
Applicable	**2.2.2** Establish or expand on a system to track and report readmission rates, timeliness of discharge summaries, and other transition processes, and investigate system-specific root causes/risk factors for readmission, using quantitative and qualitative information to identify the key causes of readmissions, including physical, behavioral and social factors.
Applicable	**2.2.3** Develop and implement a process, including utilization of data and information technology, to reliably identify hospitalized patients at high-risk for readmission.
Applicable	**2.2.4** Develop standardized workflows for inpatient discharge care: • Optimize hospital discharge planning and medication management for all hospitalized patients. • Implement structure for obtaining best possible medication history and for assessing medication reconciliation accuracy. • Develop and use standardized process for transitioning patients to sub-acute and long term care facilities. • Provide tiered, multi-disciplinary interventions according to level of risk: o Involve mental health, substance use, pharmacy and palliative care when possible. o Involve trained, enhanced IHSS workers when possible. o Develop standardized protocols for referral to and coordination with community behavioral health and social services (e.g., visiting nurses, home care services, housing, food, clothing and social support). Identify and train personnel to function as care navigators for carrying out these functions.
Not Applicable	**2.2.5** Inpatient and outpatient teams will collaboratively develop standardized transition workflows: • Develop mechanisms to support patients in establishing primary care for those without prior primary care affiliation. Develop process for warm hand-off from hospital to outpatient provider, including assignment of responsibility for follow-up of labs or studies still pending at the time of discharge.

Check, if applicable	Description of Core Components
Applicable	**2.2.6** Develop standardized workflows for post-discharge (outpatient) care: • Deliver timely access to primary and/or specialty care following a hospitalization. • Standardize post-hospital visits and include outpatient medication reconciliation.
Not Applicable	**2.2.7** Support patients and family caregivers in becoming more comfortable, competent and confident in self-management skills required after an acute hospitalization by providing: • Engagement of patients in the care planning process. • Pre-discharge patient and caregiver education and coaching. • Written transition care plan for patient and caregiver. • Timely communication and coordination with receiving practitioner. Community-based support for the patient and caregiver post hospitalization focusing on self-care requirements and follow-up care with primary and specialty care providers.
Not Applicable	**2.2.8** Engage with local health plans to develop transition of care protocols that ensure: coordination of care across physical health, substance use disorder and mental health spectrum will be supported; identification of and follow-up engagement with PCP is established; covered services including durable medical equipment (DME) will be readily available; and, a payment strategy for the transition of care services is in place.
Applicable	**2.2.9** Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**2.2.10** Increase multidisciplinary team engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on care model.
Not Applicable	**2.2.11** Implement a system for continual performance feedback and rapid cycle improvement that uses standard process improvement methodology and that includes patients, front line staff and senior leadership.

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

Through this project we seek to implement specially designed interventions for high-risk patients in order to change health system utilization patterns and improve overall health. Our planned implementation approach includes:

- *Pilot Program.* This project will build on a pilot program called CareConnect that began in July 2015 at West County Health Center. We designed CareConnect after careful review of programs nationwide. Eligibility criteria is two hospitalizations and four ED visits in the past six months. The target enrollment for this pilot is 150 patients, with at least 56 currently enrolled. Each enrolled patient is assessed in each domain and provided with appropriate levels of care with individual care plans. For example, the highest level of care for behavioral health entails weekly clinic or in-home visits by our LCSW and/or our substance abuse counselor; the lowest level entails a monthly visit or phone call. A patient assessed for our highest level of medical care receives weekly clinic (with PCP) or home visits (with nurse manager or the patient's PCP), while a patient assessed at our lowest level initiates these visits as needed. In-clinic care is coordinated by two RNs and a CHW. Nurse case managers carry a caseload of 15-20 patients. When patients are ready, they meet with their team in the clinic. In addition to the two RNs and one CHW, the team includes a lead physician, five nurse case managers, one LCSW, one substance abuse counselor, a housing case manager (to be hired), and a program manager. Enrolled patients can access same-day mental health, substance abuse and medical care. The team also provides continuity of care and case management for patients transitioning to and from treatment facilities, including medication reconciliation carried out by nurse case managers. All clinicians on the team help patients establish trusting relationships, engage in behavior that is focused on harm-reduction and develop higher levels of self-reliance.
- *Pilot Analysis.* Based on the initial results of the pilot, expected at the end of DY11, the interdisciplinary team will refine the approach and over time spread the intervention. Improvement targets are reducing avoidable ED visits and hospital days by 20% from baseline within 6-12 months of enrollment.
- *Oversight.* The CareConnect pilot is overseen by a steering committee comprised of representatives from CCRMC and HCs, behavioral health, public health, the Contra Costa Health Plan and county homeless services. We plan to add a patient or family representative in DY11. The committee will ensure adequate resources and avoid duplication of efforts in other county divisions.
- *Care Team Training.* We will provide training, coaching and monitoring and develop a workforce assessment to make sure we have the capacity to conduct this work.

- *Technology-Enabled Data Systems.* Build a process to assign Medi-Cal fee-for-service patients to care coordinators because these patients are not auto-assigned through our current system. We expect this work to begin in DY12.

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

Target Population. Our target population is currently in place with the pilot but that criteria may change over time as we expand the program and refine our approach.

Vision for Care Delivery. We seek to break the cycle of avoidable readmissions and unnecessary ED visits for our high-risk patients with complex care needs. Our approach includes multidisciplinary, high-touch interventions and rigorous tracking and follow-up to make sure patient needs are met and interventions are working. We involve stakeholders across county divisions in the planning and implementation to strengthen resources for high-risk patients and avoid redundancies in services. We seek to better understand health system utilization patterns to help patients with complex needs find more appropriate services and support while addressing individual health problems in a coordinated and sustained approach.

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

Check, if applicable	Description of Core Components
Applicable	**2.3.1** Develop a complex care management program at one site or with one defined cohort, or expand an existing program from a pilot site to all sites or to additional high-risk groups and demonstrate engagement of patients in the design and implementation of the project.
Applicable	**2.3.2** Utilize at least one nationally recognized complex care management program methodology.
Applicable	**2.3.3** Identify target population(s) and develop program inclusion criteria based on quantitative and qualitative data (e.g., acute care utilization, lack of primary care utilization, number of high-risk medical mental or SUD conditions, polypharmacy, primary care input, functional status, patient activation, social support or other factors). Include patient factors associated with a higher probability of being impacted by complex care management.
Applicable	**2.3.4** Conduct a qualitative assessment of high-risk, high-utilizing patients.

Check, if applicable	Description of Core Components
Applicable	**2.3.5** Establish data analytics systems using clinical data sources (e.g., EHR, registries), utilization and other available data (e.g., financial, health plan, zip codes), to enable identification of high-risk/rising risk patients for targeted complex care management interventions, including ability to stratify impact by race, ethnicity and language.
Applicable	**2.3.6** Develop a multi-disciplinary care team, to which each participant is assigned, that is tailored to the target population and whose interventions are tiered according to patient level of risk.
Applicable	**2.3.7** Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets.
Applicable	**2.3.8** Implement evidence-based practice guidelines to address risk factor reduction (smoking cessation/immunization/substance abuse identification and referral to treatment/depression and other behavioral health screening, etc.) as well as to ensure appropriate management of chronic diseases: • Use standardized patient assessment and evaluation tools (may be developed locally, or adopted/adapted from nationally recognized sources). • Use educational materials that are consistent with cultural, linguistic and health literacy needs of the target population.
Applicable	**2.3.9** Ensure systems and culturally appropriate team members (e.g. community health worker, health navigator or promotora) are in place to support system navigation and provide patient linkage to appropriate physical health, mental health, SUD and social services. Ensure follow-up and retention in care to those services, which are under DPH/DMPH authority, and promote adherence to medications.
Applicable	**2.3.10** Implement technology-enabled data systems to support patients and care teams throughout the care management program including patient identification, pre-visit planning, point-of-care delivery, care plan development and population/panel management activities.
Applicable	**2.3.11** Implement a data-driven system for rapid cycle improvement and performance feedback to address quality and safety of patient care, which includes patients, front line staff and senior leadership.

☒ 2.4 – Integrated Health Home for Foster Children

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]

We selected this project to address an unmet and urgent need for integrated care to foster children in our community. This project builds on our broader ambulatory care redesign efforts and behavioral health integration.
Our planned implementation includes:

- *Needs Assessment.* We will conduct an assessment to identify barriers as to why foster children are not seeking or receiving care. Currently, we have 40 available primary care appointments per month allocated to foster children but on average only eight slots per month are filled. Additionally, only 23% of foster care children in our county receive a medical assessment within 30 days of being placed in a foster care home, as required by law. This assessment will begin in DY11.
- *Resource Assessment.* We will conduct an inventory of available resources for foster children patient care. This includes our mobile health clinic services and partnerships with schools in the county.
- *Community Coordination.* This project will draw on a foster care collaborative that formed in 2010 between child welfare services, public health, clinical services, schools and domestic violence programs in our county. We will convene this collaborative in DY11.
- *Care Team Training*. We are training our pediatricians and staff on documentation and communication for foster children patient visits. This work will begin in DY11.
- *Technology-Enabled Interventions.* We are developing the capacity to match child welfare databases with our EHR system so we can identify children seen in our system who are in foster care. This ability will allow us to conduct outreach to foster families to get children in for appointments. It will also allow our providers during visits to identify foster children (who may not self-identify) and use appropriate interventions and communications.

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

Target Population. More than 1,400 children in foster care are under the supervision of Contra Costa County. For the purposes of this project, we are focusing on this population. These children are spread throughout the county, with the largest share (700 children) in east county.

Vision for Care Delivery. Providing integrated care to foster children can improve our opportunities to reach foster children and foster families in our communities. Improving outcomes for foster care children, who are among our most vulnerable, contributes to the health of our entire community.

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

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

Check, if applicable	Description of Core Components
	o Developmental assessment, identification and treatment
Applicable	**2.4.4** Implement technology-enabled data systems to support pre-visit planning, point-of-care delivery, population/panel management activities and care coordination. Timely, relevant and actionable data is used to support patient engagement, and drive clinical, operational and strategic decisions including continuous QI activities.
Applicable	**2.4.5** Provide linkages to needed services that at a minimum includes child welfare agency, mental health, substance abuse and public health nursing as well as any other social services that are necessary to meet patient needs in the community.
Applicable	**2.4.6** Develop liaisons/linkage with school systems.
Applicable	**2.4.7** Provide timely access to eligibility and enrollment services as part of the health home services.
Applicable	**2.4.8** Evidence-based practice guidelines will be implemented to address risk factor reduction (e.g., immunization, smoking cessation, behavioral health screening) as well as to ensure appropriate management of chronic diseases (e.g., asthma, diabetes). Assessment of social service needs will be integral to these activities. Educational materials will be utilized that are consistent with cultural and linguistic needs of the population.
Applicable	**2.4.9** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement, that includes patients, front line staff, and senior leadership.

☒ 2.6 – Chronic Non-Malignant Pain Management

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]

We chose this project because painkiller abuse is a pressing issue in our community. In 2014, 72 of the 96 accidental, drug-related deaths investigated by our county coroner's office involved prescription medications, either alone or combined with other substances. This project will help us achieve our strategic goals of improving patient health and safety and access to appropriate care.

Our planned implementation approach includes:

- *Pilot Testing.* We are testing a “Share the Care“ model at one health center. In this pilot, a multidisciplinary team operates a clinic to assess patients with chronic non-malignant pain. Program evaluation uses five metrics with initial results expected at the end of DY11.
- *Population Baseline.* Establish baseline of patients with non-malignant chronic pain who have opioid prescriptions. This work will begin in DY11.
- *Complementary Therapies.* Create a comprehensive flow diagram for chronic pain services, including access to complementary services like our acupuncture clinic.
- *Prescribing Policy Standardization.* Develop a policy on opioid use for chronic pain. We expect this policy to be approved by the end of DY11.
- *Provider Education.* Educate physicians, residents and other frontline staff on documentation and policies for safe prescribing. We are participants of the California Health Care Foundation's action group on safe prescribing.
- *Stakeholder Engagement.* Through our internal Safe Opioid Prescribing and Review Committee (SOPARC), we will work with internal and external stakeholders on adoption of appropriate protocols.
- *Screening Tool Implementation,* Collaborate with behavioral health integration care teams on SBIRT screening for patients identified with chronic non-malignant pain.

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

Target Population: Our target population is patients with nonmalignant chronic pain. As stated above we do not yet have baseline numbers on this population.

Vision for Care Delivery: We view this project as a crucial component of our overall goal of eliminating painkiller abuse and improve safe pain management options for people with chronic non-malignant pain. Our shared vision is to have a standardized evaluation for pain treatment; risk stratification; treatment planning and objectives; ongoing assessments of patients; and adherence monitoring. An important aspect is weaning patients off opioid therapy and supporting and expanding non-pharmacological therapies that help manage chronic pain.

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.
Not Applicable	**2.6.2** Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**2.6.3** Implement or adapt a state or nationally recognized methodology for the assessment and management of chronic pain.
Applicable	**2.6.4** Implement protocols for primary care management of patients with chronic pain including: • A standard standardized Pain Care Agreement. • Standard work and policies to support safe prescribing practices. • Comprehensive pain history including psycho/social evaluation, functional evaluations, care plan, pain medication risk/benefit informed consents, ongoing monitoring of plan/outcomes (e.g., use of standardized monitoring template for follow-up visits for CNP), aberrant behavior screening and management protocols. • Guidelines regarding maximum acceptable dosing.
Not Applicable	**2.6.5** Provide culturally, linguistically and literacy level-appropriate patient education on the pathology of chronic pain, rationale for rehabilitation and expected goals of treatment.

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.
Not 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.
Not Applicable	**2.6.10** Establish a policy for monitoring and maintaining opioid agreements for prescription refills with other clinics, pharmacies, dentists and specialists.
Not Applicable	**2.6.11** Develop a process for scheduling pain focused follow-up patient visits to ensure that patients receive refills in a timely manner while also receiving recommended monitoring for signs of diversion or misuse.
Not Applicable	**2.6.12** Develop staff and clinician training regarding the organization's process for managing patients with chronic non-malignant pain.
Not Applicable	**2.6.13** Train providers to identify signs of prescription opioid use disorders and provide treatment options for patients diagnosed with opioid use disorders, including suboxone treatment, referral to methadone maintenance, referral to inpatient and outpatient substance use disorder treatment facilities, and referral to needle exchanges.
Not Applicable	**2.6.14** Develop and implement protocols for prescribing naloxone to patients receiving opioids for chronic pain.
Not Applicable	**2.6.15** Identify standardized multidimensional pain assessment, functional assessment, psychological assessment, and opioid assessment tools that meet the needs of the care clinicians and are appropriate for the patient populations.

Check, if applicable	Description of Core Components
Not Applicable	**2.6.16** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. Timely, relevant and actionable data is used to support patient.

Please complete the summary chart:

	For DPHs	For DMPHs
Domain 2 Subtotal # of DPH-Required Projects:	**3**	**0**
Domain 2 Subtotal # of Optional Projects (Select At Least 1):	**2**	
Domain 2 Total # of Projects:	**5**	

Section 4.3 – Domain 3: Resource Utilization Efficiency

☒ 3.2 – Resource Stewardship: High Cost Imaging

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]

We chose this project to improve patient safety and establish patients as partners in decision-making. Educating family medicine and emergency physicians and their patients on guidelines for appropriate timing and indications for imaging can help us achieve these goals.

Our planned implementation approach includes:

- *Criteria selection.* We will adopt definitions for appropriate imaging using nationally recognized guidelines in DY11.
- *Scope assessment.* We will conduct chart audits and provider surveys on radiology ordering behaviors to determine the scope of inappropriate image ordering within our system. This will allow us to better gauge the mindset of our providers and where to target our education efforts. We expect initial surveys to be completed in DY 11. Additionally, we will query baseline imaging metrics and compare them moving forward to gauge ongoing impact.
- *Education.* We are already a partner with Consumer Reports on the *Choosing Wisely* campaign, and have created co-branded educational materials including screensavers, brochures, posters and videos in multiple languages. These materials will be rolled out within our system to reach patients and providers during DY 11.
- *Technology-based interventions.* We intend to create appropriate prompts within our electronic medical record system that will alert providers to best practices when they seek to order certain imaging tests that are the focus of this project. Not only will this serve as a reminder to physicians about appropriate imaging guidelines, but also will be a way for us to track physician behavior and whether the prompts are working or are ignored. These EHR prompts will be rolled out in DY12.

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

[130]

Target Population: Our target population is primary care and emergency providers and patients. We expect to learn more about provider and patient perceptions and behaviors around image ordering. This will allow us to adjust our strategy, as necessary, around interventions and campaigns to reduce the overuse of imaging within our system and create permanent behavior change.

Vision for Care Delivery: We view this project as an opportunity to elevate physician-patient engagement with our system to one where each party makes an informed decision based on evidence-based guidelines. This type of conversation-starter can lead to other improvements in patient and provider engagement and experience. If a patient feels empowered to ask their provider about appropriate imaging, it can create the opportunity for informed and engaging discussions around other aspects of care.

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

Check, if applicable	Description of Core Components
Applicable	**3.2.1** Implement an imaging management program, demonstrating engagement of patients in the design and implementation of components of the project.
Applicable	**3.2.2** Program should include identification of top imaging tests whose necessity should be assessed for possible overuse. Criteria for assessment could include: • Frequency and cost of inappropriate/unnecessary imaging: o Appropriate Use: Beginning with state- or nationally-recognized models or guidelines (e.g., American College of Radiology Appropriateness Criteria, American College of Cardiology Appropriate Use Criteria) and incorporating pertinent local factors, programs will set out definitions for appropriateness. o Cost: Programs will identify imaging studies associated with high costs due to high cost per study or high volume across the system. • Unwarranted practice variation within the participating DPHs/DMPHs. Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed. • Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed. • Whether there are established, tested and available evidence-based clinical pathways to guide cost-effective imaging choices.
Applicable	**3.2.3** Establish standards of care regarding use of imaging, including: • Costs are high and evidence for clinical effectiveness is highly variable or low.

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

Please complete the summary chart:

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

Section 5: Project Metrics and Reporting Requirements

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

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

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

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

Section 6: Data Integrity

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

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

Section 7: Learning Collaborative Participation

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

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

Section 8: Program Incentive Payment Amount

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

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

- DY 11 $ 75,265,400
- DY 12 $ 75,265,400
- DY 13 $ 75,265,400
- DY 14 $ 67,738,860
- DY 15 $ 57,578,031

Total 5-year prime plan incentive amount: $ 351,113,091

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- Section 3.1.2