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

UCLA Health System / Ronald Reagan UCLA Medical Center (RUMC), Santa Monica-UCLA Medical Center and Orthopaedic Hospital (SM-UCLA & OH)

Health Care System Designation(DPH or DMPH)

DPH

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.

Health Care Access

- In our service area, 92.6% of the population is insured. When insurance coverage for the service area is examined by zip code, 11.8% of area residents are uninsured. There is a large variation between those areas with the best coverage in Bel Air, with 2.6% uninsured, and those with the highest percent of uninsured in Palms, with 20.9% uninsured.

Insurance Status

	UCLA Health Service Area	Los Angeles County	California
Insured	92.6%	86.7%	88.1%
Uninsured	7.4%	13.3%	11.9%

Source: California Health Interview Survey, 2014. http://ask.chis.ucla.edu/

- 17.9% of the population visited an ER over the period of a year, and youth visited the ER at the highest rates (28.3%).
- 14.4% of the population delayed or did not get medical care when needed, and 4.4% delayed or did not fill prescriptions.
- 11.3% of children had never been to a dentist. 19.4% of adults reported not going to the dentist because they were unable to afford dental care.

Chronic Disease

- Among the residents in our service area, 9.8% indicate they have fair or poor health status. The level of fair or poor health increases among seniors. 19.3% of seniors consider themselves to be in fair/poor health.
- 7% of the population in our service area has been diagnosed with asthma. Among those with asthma, 28.6% take medication to control their symptoms. Among youth, 7.8% have been diagnosed with asthma.
- 4.6% of adults in our service area reported they have been diagnosed with diabetes. For adults with diabetes, 69.6% were very confident they can control their diabetes, while 15.7% were not confident.

- For adults in our service area, 4.8% have been diagnosed with heart disease. Among these adults, 66.7% are very confident they can manage their condition.
- Rates of HIV/AIDS new diagnoses are highest among males, young adults 20-29, and Blacks/African Americans. 83% of the new cases were reportedly via male-to-male sexual contact, 10% via heterosexual sex, and 6% were cases where IV drug use was implicated.

Leading Causes of Death

- Heart disease, cancer, and stroke are the top three leading causes of death in the service area. When compared to the county and state, the service area has higher death rates for the top three causes of death.
- Coronary heart disease was the leading cause of premature death, followed by suicide, drug overdose, motor vehicle crashes, and liver disease.

Source: UCLA RR Community Health Needs Assessment 2016

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.

The service area includes 28 zip codes, representing 18 cities or communities with the following demographics:

- Children and youth, ages 0-17, make up 16% of the population; 69.7% are adults, ages 18-64; and 14.3% of the population are seniors, ages 65 and over. The median age is 37.9.
- 60.2% of the service area population is White; 16.5% of residents are Hispanic/Latino; 13% are Asian; 6.2% are African American; and 4.1% are American Indian/Alaskan Native, multiple, or other race/ethnicity.
- English is spoken in the home among 64.4% of the service area population. Spanish is spoken at home in 13.3% of the population; 8.1% speak an Asian language; and 11.8% speak an Indo-European language at home.

Social and Economic Factors

- In the service area, 11.9% of the population is at or below 100% of the federal poverty level (FPL). Close to one-quarter (24%) of the population is considered low-income, living at or below 200% of FPL.
- The median household income ranges from $54,373 in Palms to $168,036 in Bel Air.
- Unemployment rates in service area cities range from 4.8% in Malibu to 8.7% in Los Angeles City.
- Among the homeless population, 43% are chronically homeless. The rates of chronic homelessness have increased from 2013 to 2015. Those who are

homeless have high rates of mental illness (40.9%) and 20.8% are homeless veterans.

Source: UCLA RR Community Health Needs Assessment 2016

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.

The UCLA Hospital System is comprised of three licensed hospitals: Ronald Reagan UCLA Medical Center, Santa Monica-UCLA Medical Center and Orthopaedic Hospital, and the Stewart and Lynda Resnick Neuropsychiatric Hospital. The UCLA Health outpatient clinics are licensed.

The FY15 payor mix was 29% Medicare, 17% Medi-Cal, 71% Contract, 4% Capitation and 1% Sponsored based on discharges.

Ronald Reagan UCLA Medical Center

RRUMC provides internationally recognized patient care in nearly every medical specialty and is recognized as the largest solid-organ transplant hospital in the U.S. In addition, RRUMC is nationally recognized in the several clinical areas, including but not limited to the neurosciences, oncology, cardiovascular sciences, urology, orthopedics, geriatrics, and gastroenterology. The hospital has 520 private patient rooms.

Santa Monica-UCLA Medical Center and Orthopaedic Hospital

The 271 bed hospital operates many outstanding clinical programs, including women's and children's services, emergency services and family medicine. It also serves as the clinical home of the UCLA Comprehensive Spine Center and inpatient home of the UCLA Geriatrics Program.

Stewart and Lynda Resnick Neuropsychiatric Hospital

NPH is an independently accredited and licensed hospital located in RRUMC. The facility offers a continuum of psychiatric services with 74 private patient rooms.

UCLA's Mattel Children's Hospital

Located within RRUMC, Mattel includes a 90-bed inpatient unit and an outpatient Children's Health Center. It provides pediatric oncology services, pediatric emergency, trauma and burn care, intensive care, neonatal intensive care, brain surgery, heart surgery, kidney and liver transplants, pediatric mental health care and research into neuro-developmental disorders including autism. Its neonatal intensive care unit and pediatric intensive care unit are California Children's Services designated regional centers.

UCLA Health Outpatient and Ambulatory Services.

UCLA Health offers a wide range of both hospital outpatient and ambulatory physician-office based services that span the full spectrum from adult and child primary care through all forms of specialty care. The major hubs are located at or near our hospitals in West Los Angeles and Santa Monica. Currently UCLA Health has more than 150

hospital outpatient and ambulatory physician-office locations from Ventura to Palos Verdes.

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.

UCLA Health System has an enterprise electronic medical record we refer to as CareConnect (Epic). All clinical care within the ambulatory clinics, operating rooms, and hospitals described in Section 2.3 above, as well as all laboratory, radiology, and financial data, are all documented within CareConnect. All of these data are captured and integrated into the Clarity relational database. Currently, UCLA has developed a data model that overlays this database. From this, various teams develop quality, financial, and other types of reports. Some of these reports are used for internal quality improvement activities, and others are used to meet external reporting requirements for example core measures. These reports can be and are generated on a regular and ongoing basis. Teams of clinical and administrators currently track various metrics through these regular reports. This infrastructure for collecting the raw data, developing the required reports, and tracking performance over time will all be leveraged for the PRIME reporting requirements.

In the event data abstraction presents a challenge, we are prepared to expand our clinical surveillance program with additional analysts.

For certain innovative measures which have ongoing data definitions, manual chart abstraction may be necessary. In the event of chart abstraction, our computer analysts will assist insofar as to automate as much of the data abstraction as possible and leverage our existing framework of databases to capture most of the data, changing the abstraction process to validation rather than creation; the goal is to create easily reviewed records.

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.*

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.*

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;*

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

5. *Provide a succinct summary description of how your hospital or health system will be transformed at the end of the five years. Explain how this transformation should result in advances in clinical, population health, fiscal or other critical outcomes through PRIME.*

The overarching goals of the PRIME plan align with UC's commitment to achieving continuous improvement in patient care and the delivery of services that are

increasingly patient-centered, innovative, effective and evidence-based. In addition, our plan is aligned with national health reform goals of improving clinical outcomes, patient safety, quality, patient satisfaction and delivery-system efficiencies. UCLA Health will use PRIME as a vehicle for accelerating delivery-system transformation within the context of national health reform, transitioning from longstanding systems of care that were often fragmented, to increasingly integrated systems of patient-centered care that are better equipped to manage the health of populations. Transformation of any kind faces barriers to success. Among these are challenges related to: shortages of primary care providers; managing access to specialists; limiting unnecessary use of high-cost services; reducing hospital-acquired conditions; and improving chronic disease management and care across the continuum, including transitioning patients safely from acute inpatient settings, to ambulatory clinics and home.

In this proposal, the UCLA Health will address the following challenges:

- Over a third (37%) of adults who needed help for an emotional or mental health problem in our service area did not receive treatment (source: UCLA RR Community Health Needs Assessment 2016).
- Access to high quality primary care and specialty care is inadequate, particularly for the uninsured and for individuals with complex chronic conditions;
- Patients do not receive well-coordinated care across primary, specialty, inpatient, and community care domains. As a result, patients may return to the emergency department or hospital for preventable reasons;

To do this, the UCLA Health System will establish a five-year implementation plan that includes targeted investments, enhancements, and outcome measurement/milestones in the following key areas:

1. **Behavioral Health Assessment Tool and Registry**: Improve access to timely, high quality behavioral health prevention and treatment, reduce ED visits and improve outcomes for primary care patients. Expand screening and clinical decision making tool for early identification, education and intervention and ensure appropriate referral.
2. **Care Redesign:** Identify high risk patients, maximize contributions around transitions of care, execution of care plans, referral to appropriate community resources, monitoring to ensure care plans are executed, and communication of patient issues within the care team, establish structured care agreements to guide interactions between primary care and specialist providers
3. **Improve Perinatal Care:** Assess factors and implement programs that aim to reduce delays in access to the first prenatal visit.
4. **Expanded access to specialty care:** Enhancement of access to critical specialty care or a cohort of patients who current lack timely consultation and treatment;
5. **Decision Support**: Enhance the health information technology infrastructure to allow for point-of-care decision support for medication management, palliative care, and care coordination

6. **Quality Indicators**: Improve inpatient quality indicators and overall patient safety within the health system.
7. **Medical Home**: Expand upon our existing care coordination program for adult primary care and use the lessons learned from our Pediatric Medical Home program at UCLA;

The selected projects are important elements of UC medical center strategies for achieving the Triple Aim of improving the patient care experience, managing the health of populations and reducing per capita health care spending. As a result of this plan, the UCLA Health System will reform its delivery system by improving patient care in an effective and efficient manner - leading to an improvement in access, quality, and a reduction in overall health care costs, with particular emphasis on those in underserved communities. These programs will be further detailed in Section 4 below.

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.

As outlined in Section 2, our service area has higher than average leading causes of death for heart disease, cancer and stroke. We aim to focus systematic attention and resources in Project 2.3: Complex Care Management for High Risk Medical Populations to those with high medical complexity. We anticipate that this emphasis on the highest utilizers has the greatest potential for value, improving quality while reducing overutilization of health care resources, tying in with the Triple Aim. We successfully demonstrated the value of this approach in our system with pediatric and young adult populations; our pediatric medical home program has been shown to decrease hospitalization rates by 60%, readmissions rates by 25%, and ED visit rates by 50% in this very high utilizing population, while achieving high rates of patient satisfaction.

In addition, Project 1.3 Ambulatory Care Redesign: Specialty Care, will enable UCLA to extend our existing primary care-based innovations to our specialty practices, creating a system-wide “medical neighborhood” for our patients. As we discuss in project 1.2: Ambulatory Care Redesign: Primary Care, our approach to strives to integrate care coordination services in a tight linkage to primary care practices, so that patients will understand and value that their care is being directed by their usual source of care, and not an external entity with the intention of increasing the likelihood of successful programs.

Members of the UCLA Health community represent the voice of the patient. We engage our stakeholders by patient representation on our Infection Control Committee (as a standing member), Patient Family Advisory Committee (PFACS), and new hire orientation. During New Hire Orientation, a community member speaks to all new hires during the first day of orientation on the topic of the patient voice. In addition, we

conducted interviews with our stakeholders as part of our community health needs assessment as described below.

Primary Data Collection

Targeted interviews were used to gather information and opinions from persons who represent the broad interests of the community served by the hospital. Given shared service areas, UCLA Health partnered with Cedars-Sinai Medical Center, Kaiser Foundation Hospital – West Los Angeles and Providence St. John's Health Center to conduct the interviews. Twenty-five (25) interviews were completed during September through November, 2015.

For the interviews, community stakeholders identified by UCLA Health, in partnership with Cedars-Sinai Medical Center, Kaiser Foundation Hospital – West Los Angeles and Providence St. John's Health Center, were contacted and asked to participate in the needs assessment. Interviewees included individuals who are leaders and representatives of medically underserved, low-income, and minority populations, or local health or other departments or agencies that have "current data or other information relevant to the health needs of the community served by the hospital facility." Input was obtained from Los Angeles County Department of Public Health officials.

The identified stakeholders were invited by email to participate in a one hour phone interview. Appointments for the interviews were made on dates and times convenient to the stakeholders. At the beginning of each interview, the purpose of the interview in the context of the assessment was explained, the stakeholders were assured their responses would remain confidential, and consent to proceed was given. A list of the stakeholder interview respondents, their titles and organizations can be found in Attachment 1.

Initially, significant health needs were identified through a review of the secondary health data collected and analyzed prior to the interviews. These data were then used to help guide the interviews. The needs assessment interviews were structured to obtain greater depth and richness of information and build on the secondary data review. During the interviews, participants were asked to identify the major health issues in the community, and socioeconomic, behavioral, environmental or clinical factors contributing to poor health. They were asked to share their perspectives on the issues, challenges and barriers relative to the identified health needs, and identify resources to address these health needs, such as services, programs and/or community efforts. The interviews focused on these identified health needs:

- Access to care
- Asthma
- Cancer
- Community safety
- Dental care
- Diabetes
- Heart disease
- HIV/AIDS
- Homelessness/housing
- Mental health
- Overweight and obesity
- Preventive practices
- Substance abuse

Interview participants were asked to provide additional comments to share with UCLA Health. Analysis of the primary data occurred through a process that compared and combined responses to identify themes. All responses to each question were examined together and concepts and themes were then summarized to reflect the respondents' experiences and opinions. The results of the primary data collection were reviewed in conjunction with the secondary data. Primary data findings were used to corroborate the secondary data-defined health needs, serving as a confirming data source. The responses are included in the following Community Health Needs Assessment chapters.

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 DY 11 UCLA will create the PRIME Oversight Committee with the goal of organizational oversight and adherence to the UCLA PRIME plan. The PRIME Project Manager is responsible for coordination of activities and sharing of overall progress by convening the PRIME Oversight Committee. The committee, comprised of physicians,

process owners, and technical staff, has already met once and will meet roughly quarterly. The potentially decentralized nature of the data collection activities poses process management challenges. To overcome this challenge, a comprehensive data validation and retention process is underway to ensure consistent data collection and that each project is integrated in to existing measurement or reporting. For example, the project lead for each PRIME project is a subject matter expert and is already responsible for the data reporting for similar national measures relating to their project. Each project lead will rely on our analytics team to adjust existing reports and dashboards to include PRIME metrics.

We will use our in-house analytic services, as described in section 2.4, to analyze baseline data from DY 11 and complete a gap analysis identifying the with the greatest gap between actual performance and potential performance within each project to the extent the data is available. This will ensure we align our transformational efforts with data-driven quantitative and qualitative analysis, specific to each project and incorporating the unique challenges each project present.

The PRIME Oversight Committee is co-led by the Chief Medical and Quality Officer, the Chief Administrative Officer and the Chief Medical Officer of the Faculty Practice Group. This integrates PRIME in the overall governance of the oversight and structure of the UCLA Health System.

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.

UCLA plans to create sustainable projects by establishing clearer channels of communication between participating physicians across the health system and with our patients. Our success depends on our ability to engage and involve our patients in the continuum of care. Specifically, we plan to:

- Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. **Most projects**
- Create shared learning opportunities among projects and hospitals **All projects**
- Work with high risk patients or develop processes for local care coordinators to work with these patients. **Project 1.2**
- Demonstrate engagement of patients in the design and implementation of the project. **Project 1.3**
- Engage patients and support care teams with patient identification, pre-visit planning, point of care delivery, and population/panel management activities. **Project 1.4**
- Achieve baby-friendly hospital designation through supporting exclusive breastfeeding prenatally, after delivery, and for 6 months after delivery and using lactation consultants after delivery. **Project 2.1**
- Develop mechanisms to support patients in establishing primary care for those without prior primary care affiliation. **Project 2.2**

- Establish care goals consistent with patient and family preferences, including a holistic approach that includes spiritual and emotional needs. **Project 2.7**

Activities to engage our internal stakeholders include regular presentation on projects, status updates and progress at our Clinical Excellence Committee and Primary Care Innovation Model (PCIM) Design Team meetings by the PRIME project coordinator. Both groups include senior leadership for the Health System and include oversight of inpatient and outpatient patient care areas. This presents an opportunity for feedback from senior leaders and a multidisciplinary team to incorporate in planning at the project level.

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.

In Project 1.2 we mark that we plan to hire and train 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.

In project 2.7 we outline that we plan to Establish or expand both ambulatory and inpatient palliative care (PC) programs that provide effective communication (culturally and linguistically appropriate).

As we mark in project 2.3, we plan to 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 by using educational materials that are consistent with cultural, linguistic and health literacy needs of the target population.

Among the patients in our service area who have been diagnosed with diabetes, over 30% of adults are ‘somewhat confident’ or ‘not confident’ in their ability to control diabetes. In Project 2.1 we plan to coordinate care for women in the post-partum period with co-morbid conditions including diabetes and hypertension.

3.6 Sustainability. [No more than 150 words]

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

The Health System plan for all PRIME projects is to build on successful projects that have emerged from previous DSRIP projects, current health system initiatives, and planned programs which align with the strategic vision for the future. As outlined in

section 3.3, the structure we plan is to incorporate PRIME by building on these programs and using subject matter experts.

In addition, we will incorporate Lean training and the adoption of Lean principles in our PRIME plans. Our Lean objectives aim to accelerate system wide improvements in care coordination and delivery. Lean adoption requires buy-in from the entire organization: administrators, clinicians, information technologists, front-line staff and support staff.

By incorporating Lean principles and being cognizant to align PRIME projects with existing and planned initiatives we are building a framework of sustainability into the foundation of each project to be sustainable beyond DY15.

Section 4: Project Selection

The PRIME Projects are organized into three Domains:

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

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

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

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

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

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

Instructions

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

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

1. *Summarize your approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words]*
2. *Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]*

3. ***For DMPHs (as applicable),*** *indicate which project(s) your entity is selecting that will require infrastructure-building process measures and complete the supplemental document (Appendix) to identify and describe your proposed process measures.*

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

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

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

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

1. UCLA Health plans to address untreated mental illness and substance use disorders on physical and behavioral health status through the expanded integration of behavioral health care within a large primary care network. The prevalence of mental illness within UCLA primary care patients is about 21% (FY 14). We have recently initiated an integrated care model using the Collaborative Care Model in order to improve patient access, reduce ED visits, and improve physical and behavioral health patient outcomes. UCLA's advanced primary care program, which includes integrated behavioral health as well as care coordination efforts will facilitate the work of clinical screening and case management. Throughout PRIME, we plan to address the following core components by enhancing and expanding our integrated model in alignment with required project metrics.

Planned implementation includes:

- Behavioral health assessment tool and registry: UCLA will expand a pilot of a secure, cloud-based screening and clinical-decision making tool to support early identification, targeted education, brief intervention, appropriate referrals for behavioral health and SUDs. Automated scoring and interpretation provides real-time feedback and guidance to optimize decision-making, customize patient care, and

ensure outcome tracking. This expanded tool will support monitoring required metrics and protocols such as SBIRT and depression screening. We will design the integration plan of the tool into the electronic health record. We anticipate implementation and evaluation of this platform within the targeted primary care network.

- Care Team Training: A multidisciplinary taskforce will assess educational needs regarding evidence based behavioral health and SUD screening, intervention protocols. We will implement standardized training in the use of SBIRT screening, intervention and referrals when appropriate. We will begin this work with a needs assessment in order to design and conduct trainings.

Implementation of both core components will help improve population management and reduce barriers to substance use prevention and treatment services.

2. *Target Population:* The target population includes individuals in the PRIME eligible population and are a Medical beneficiary.

Vision for Care Delivery: The proposed PRIME projects will enable us to improve care for adult and adolescent primary care populations within a large UCLA primary care network. Aligned with our goals to improve access to timely, high quality behavioral health prevention and treatment, reduce ED visits and improve outcomes for primary care patients, these projects will expand the integrated care practices within our existing Collaborative Care Model.

a) The implementation of a web-based multidimensional, standardized screening tool and patient registry integrated into the electronic health records will enable us to accurately identify behavioral health and SUDs risk level and deliver appropriate and timely stepped care within a primary care setting, supporting enhanced access and reduced stigma associated with behavioral health care. The enhancement and expansion of the tool will facilitate routine and standardized integration of prevention and early intervention practices. Further, the tool's web-based registry will support ongoing tracking of patient outcomes to support quality improvement processes, and serve as a model for expansion to other primary care and chronic health care settings.

The planned training and implementation of SBIRT throughout the primary care setting will support early identification of alcohol and substance use problems in our adult and adolescent patient populations, reducing the burden of substance use problems on physical and mental health outcomes for our patients and costs for the health system.

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

Check, if applicable	Description of Core Components
Applicable	**1.1.1** Implement a behavioral health integration assessment tool (baseline and annual progress measurement)
Applicable	**1.1.2** Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration, the Collaborative Care Model, or other Integrated Behavioral Health (IBH) resources from SAMHSA)
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.
Not 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).
Not 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.
Not Applicable	**1.1.6** Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families.

Check, if applicable	Description of Core Components
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.
Not 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.
Not Applicable	**1.1.9** Increase access to Medication Assisted Treatment (MAT) for patients with alcohol and opioid addiction to assist in stabilizing their lives, reducing urges or cravings to use, and encourage greater adherence to treatment for co-morbid medical and behavioral health conditions. For alcohol use disorders these medications include naltrexone, acamprosate, and disulfiram. For opioid addiction, medication assisted treatment (MAT) includes maintenance treatment with methadone and buprenorphine.
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.
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.

Check, if applicable	Description of Core Components
Not Applicable	**1.1.13** Implement technology enabled data systems to support pre-visit planning, point of care delivery, care plan development, population/panel management activities, coordination and patient engagement. Develop programs to implement telehealth, eReferral/eConsult to enhance access to behavioral health services.
Not Applicable	**1.1.14** Demonstrate patient engagement in the design and implementation of the project.
Not 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.
Not 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)

1. Care coordination is a core component of PCMH models and is one of the "7 Joint Principles" promulgated by the primary care societies. Our plan is to promote a team-based approach to care coordination and population management at the local office level and leverage EHR and data systems to improve quality of care.

Our team-based practice based workforce will be composed of individuals with different levels of training based upon the requirement of each role. This will be a combination of licensed and non-licensed individuals. Our non-licensed team members will be trained to maximize their contributions around transitions of care, execution of care plans defined by licensed providers, referral to appropriate community resources, monitoring to ensure care plans are executed, and communication of patient issues within the care team.

Higher risk patients will be identified by risk assessment tools, and clinician identification. Licensed case managers and ambulatory pharmacists will be utilized as needed for more complex patients. Higher risk patients are a subset of the target population identified so more intense resources can be brought to coordinating their care. The risk assessment process aligns with the definition of the target population by applying a tool to all individuals in the target population to identify areas for opportunity

in coordination of care. This creates a bridge between Project 1.2 and 1.3 by identifying individuals who may be at risk and potentially need specialty care.

We believe that close linkage and communication with specialty practices and other embedded services, including behavioral health, advanced care planning, ambulatory pharmacist support, is a key aspect of ensuring timely provision of coordinated care that is beyond the scope of traditional primary care.

In order to have a robust ability to fill care gaps and collect needed demographic data we will develop necessary registries and connections to and within our EHR, and have other tightly integrated workflows. These improvements in data systems will improve the efficiency and effectiveness of our coordinated care.

2. *Target Population:* The target population includes those in the PRIME eligible population who are seen by a primary care team member two or more times during the measurement period and are a Medical beneficiary.

Vision for Care Delivery: Our approach to ambulatory care redesign strives to integrate care coordination services in a tight linkage to primary care practices, so that patients will understand and value that their care is being directed by their usual source of care, and not an external entity. This will improve care by making it more likely that patients actually receive needed services and avoid services not needed. By a combination of in-reach and out-reach, enabled by actionable data connected to usual workflows, appropriate patients are identified so that necessary interventions are made by members of the care team, and care gaps filled more reliably.

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.
Not 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.

Check, if applicable	Description of Core Components
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.
Not 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).
Not 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.
Not Applicable	**1.2.8** Demonstrate evidence-based preventive and chronic disease management.

Check, if applicable	Description of Core Components
Not 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)).
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.
Not 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)

1. This project will enable UCLA to extend our existing primary care-based innovations to our specialty practices, creating a system-wide “medical neighborhood” for our patients. Specifically, we will engage both primary care and specialty providers in order to:

- Establish structured care agreements to guide interactions between primary care and specialist providers – starting with a handful of specialty services, we will engage primary care and specialty leadership to develop working documents that outline expectations for referrals to that specialty and details of co-management of patients post-referral, to ensure high-quality, efficient delivery of care.
- Improve coordination for specialty care patients – We will convene a task force in DY11 of UCLA primary care and specialty providers who are currently working on issues of care coordination to apply best practices, prevent avoidable ED visits, and reduce inpatient readmissions. The task force will develop a plan to improve care coordination for patients receiving specialty services, for implementation in DY 12 and DY 13.
- Promote an efficient, collaborative referral process – In DY 11, we will systematically examine the specialty care referral process to determine the timeliness of referral adjudication and the timeliness and completion of specialist assessments as entered into the UCLA EHR. We will engage primary care physicians and specialists in DY 11 and DY 12 to define ideal management of the UCLA referral process within an Accountable Care Organization framework, in order to increase efficiency by reducing unnecessary face-to-face referrals (e.g., through expansion of our existing pilot eConsult program).
- Deliver preventive services at specialty visits – We will comprehensively assess the current practices of tobacco screening and counseling as well as influenza vaccine administration at UCLA specialty clinics. We will identify successful approaches for near-term replication, developing a preventive service delivery plan in DY11 for implementation in specialty clinics by DY 12.

2. *Target Population:* We will apply the target population criteria of the PRIME eligible population for whom any specialty care service (including behavioral health) has been requested in DY 11, acknowledging that for a subset of metrics the target population is limited to patients for whom the particular metric applies. We will use our in-house analytic services to analyze baseline data from DY 11 and complete a gap analysis identifying the specialty clinics and delivery areas with the greatest gap between actual performance and potential performance. We will initiate the work in these specialty clinics first and then subsequently implement the project in other specialty clinics.

Vision for Care Delivery: We anticipate that PRIME project 1.3 will enable UCLA to extend best practices and lessons learned from successful redesign efforts in the primary care setting to our specialty care services as well, which are already within our ACO structure. As an example, we will evaluate the existing and successful UCLA primary care-based clinic care coordinator (CCC) program to explore how it might be expanded patients receiving specialty care, such as outpatient specialty procedures. We will also plan to identify and incorporate new delivery approaches that have the potential to enhance care (e.g., specialty clinic-initiated, web-based referrals to the

California tobacco quitline that “close the loop” by providing feedback to providers on the delivery of tobacco cessation counseling). Ultimately, better integration of primary care and specialty care, with structured expectations of mutual care, will reduce fragmentation of care for our patients

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

Check, if applicable	Description of Core Components
Applicable	**1.3.1** Develop a specialty care program that is broadly applied to the entire target population.
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.
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).
Applicable	**1.3.4** Engage primary care providers and local public health departments in development and implementation of specialty care model.
Applicable	**1.3.5** Implement processes for primary care/specialty care co-management of patient care.
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.
Applicable	**1.3.8** Ensure that clinical teams engage in team- and evidence-based care.
Not 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.

Check, if applicable	Description of Core Components
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.
Applicable	**1.3.11** Adopt and follow treatment protocols mutually agreed upon across the delivery system.
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.
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.
Not 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).
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.

☒ 1.4 – Patient Safety in the Ambulatory Setting

1. At UCLA health, there are over 2.5 million ambulatory encounters each year and "only" 40,000 acute hospital discharges, demonstrating that opportunities for improved patient safety events in the ambulatory setting might be common. Our approach is to optimize our infrastructure for care management, coordination, and monitoring. Much of this is now more amenable to intervention due to our enterprise EHR implementation. Because physician and other licensed professional time is limited, we will generally seek opportunities to pre-process information so that actionable interventions can be easily confirmed and completed. We will implement clinical decision support to identify and address gaps in care at the time of visit and between visits. We will perform a baseline assessment of test ordering and follow up workflow for common (e.g. monitoring for patients on persistent medications) or higher risk tests (e.g. warfarin) and then implement technology enabled and practice based workflow solutions that have a high likelihood of improving performance.

2. *Target Population*: The target population includes those in the PRIME eligible population who are seen by a primary care team member. Specific populations will be identified by our in house analytic service, applying the measure specifications outlined by CAPH/SNI for PRIME measures. Per the measure specifications, the target population includes the combination of those in the PRIME eligible population who are seen by a primary care team member two or more times during the measurement period and individuals of all ages who are in Medi-Cal Managed Care with 12 months of continuous assignment to our facility for all 12 months of the measurement period.

Vision for Care Delivery: Unlike the more heavily resourced and regulated inpatient environment, ambulatory care generally lacks the very structured approach to process improvement UCLA will improve patient safety in the ambulatory setting by creating a more reliable and less error prone approach to test ordering, which will result in improved and a reduction in complications.

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

Check, if applicable	Description of Core Components
Applicable	**1.4.1** Perform a baseline studies to examine the current workflows for abnormal results follow-up and monitoring of individuals on persistent medications.
Not Applicable	**1.4.2** Implement a data-driven system for rapid cycle improvement and performance feedback based on the baseline study that effectively addresses all identified gaps in care and which targets clinically significant improvement in care. The improvement and performance feedback system should include patients, front line staff from testing disciplines (such as, but not limited to, radiology and laboratory medicine) and ordering disciplines (such as primary care) and senior leadership.

Check, if applicable	Description of Core Components
Not Applicable	**1.4.3** Develop a standardized workflow so that: • Documentation in the medical record that the targeted test results were reviewed by the ordering clinician. • Use the American College of Radiology's Actionable Findings Workgroup[1] for guidance on mammography results notification. • Evidence that every abnormal result had appropriate and timely follow-up. Documentation that all related treatment and other appropriate services were provided in a timely fashion as well as clinical outcomes documented.
Not Applicable	**1.4.4** In support of the standard protocols referenced in #2: • Create and disseminate guidelines for critical abnormal result levels. • Creation of protocol for provider notification, then patient notification. • Script notification to assure patient returns for follow up. Create follow-up protocols for difficult to reach patients.
Applicable	**1.4.5** Implement technology-enabled data systems to support the improvement and performance feedback system as well as engage patients and support care teams with patient identification, pre-visit planning, point of care delivery, and population/panel management activities.

Please complete the summary chart:

	For DPHs	For DMPHs
Domain 1 Subtotal # of DPH-Required Projects:	**3**	**0**
Domain 1 Subtotal # of Optional Projects (Select At Least 1):	**1**	
Domain 1 Total # of Projects:	**4**	

[1] *Actionable Findings and the Role of IT Support: Report of the ACR Actionable Reporting Work Group. Larson, Paul A. et al. Journal of the American College of Radiology, Volume 11, Issue 6, 552 – 558. http://www.jacr.org/article/S1546-1440(13)00840-5/fulltext#sec4.3, Accessed 11/16/15.*

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

☒ 2.1 – Improved Perinatal Care (required for DPHs)

1. The patient-healthcare provider partnership surrounding pregnancy and newborn care opens one of the most opportune windows to engage young at-risk populations into early and sustainable health promoting behaviors. Prevention of pre-existing medical conditions can reduce perinatal morbidities. We intend to:

- Characterize the target population receiving prenatal and postpartum care. Assess factors and implement programs that aim to reduce delays in access to the first prenatal visit. Develop systems for timely communication of inpatient and outpatient follow-up needs, which includes coordination of post-discharge planning for referred patients. Partner with primary care providers to establish an integrative model for continuity of care of at-risk women during the first 2 years after childbirth.
- Establish active tracking of obstetric hemorrhage, blood product utilization and intervention outcomes for immediate peer-review and education. Using published best practices and partnering with national and regional quality collaboratives, develop and implement proven obstetric hemorrhage care pathways.
- Peer reviews of low-risk first-birth cesarean deliveries. Given the involvement of physicians-in-training in inpatient maternity care, will facilitate educational programs to reinforce pathways for safely reducing low-risk first-birth cesareans. Improve perinatal education to empower the patient to become an active partner of her childbirth experience.
- Provide ambulatory and inpatient lactation training for existing and new providers. Identify mothers at risk for missing exclusive breastfeeding and develop strategies to extend lactation consultant services through the first 6 weeks postpartum. Ronald Reagan's on-site assessment for Baby Friendly Designation is due in DY11. In the subsequent years of PRIME, will plan to implement strategies to support exclusive breastfeeding at 6 months postpartum.

Develop an interdisciplinary task force to conduct case reviews to effectively understand the prenatal and intrapartum antecedents of newborn complications. Using published best practices, develop and implement initiatives to improve upon the system's unexpected newborn complication rate.

2. *Target Population:* The target population for our improvement efforts in all Project 2.1 metrics is all women who receive perinatal and postpartum care at UCLA Health. However, for the purposes of PRIME reporting, we will track and trend improvement on a subpopulation of women who receive perinatal and postpartum care at UCLA Health who have had two or more primary care encounters and have assigned MediCal insurance.

Vision for Care Delivery: UCLA Health aims to deliver best-practice perinatal and postpartum care through the implementation of various programming efforts and active collaboration between the patient and clinical teams to ensure high patient satisfaction across the ambulatory and inpatient setting.

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.
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.
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)

1. UCLA selected this project because of the significant need to ensure safe and timely transitions of care as patients transition from the hospital setting to the next level of care. The advantages of developing such a program include enhanced communication among hospital care team members and providers in the post acute care network. As patients transition from a hospital to a facility, a coordinated discharge and handoff process must be firmly in place to ensure that all relevant clinical, psychosocial and behavioral information is documented and communicated to the receiving provider. Such a process ensures a safe transition, continuity of care and promotes recovery. Our planned implementation approach includes:

- Transitional information packet (TIP-Red Packet) that contains face sheet, contact information, clinical information (PT/OT notes, consults, progress notes, labs, films, discharge summary, medication reconciliation, appointments) is given to both the patient and the receiving facility. We will convene a workgroup to review the information and the mode of transmission to determine improvements needed and identify a sustainable process. The workgroup will also develop a

Tip Sheet to facility providers regarding information provided in the packet and who to contact if information is missing or incomplete. This workgroup will convene in DY 12 and expect to complete the work in the same year, however we will likely continue the focus throughout PRIME.

- Warm Handoff: The same workgroup will also develop a strategy to improve provider to provider handovers on discharge to facility providers. There continues to be variation in the process, and one possible solution that was suggested was routing the Final Multidisciplinary note and discharge summary to the receiving physician through mednet email. The new AIDIN referral system may represent an option if the system could route the discharge information to the receiving provider in a timely manner.

This project focuses on patients transferring to the post acute care network including skilled nursing facilities, acute rehabilitation unit, and long term acute care facilities, which may include a community based facility.

2. *Target Population:* Our target population will include patients transferring to the post acute care network including SNFs, ARUs, and LTACs. Additionally, the patient population will be stratified by risk factors and will include select payors who typically may have patients at higher risk for comorbidities and readmissions.

Vision for Care Delivery: A care transitions program that integrates the post acute care process will improve our ability to ensure patients transition to the appropriate level of care with complete clinical information and direct communication to the providers. This program and the identified strategies will improve our care transitions process through improvements in the transitional information packets, warm handoffs and enhancing the CCTP program in SNFs.

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.
Not 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.

Check, if applicable	Description of Core Components
Not 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.
Not 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.
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.
Not 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.

Check, if applicable	Description of Core Components
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.
Not 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)

1. UCLA has been a national leader in the development and implementation of systems of care, particularly for medically complex pediatric and young adult populations. We plan to expand upon our existing care coordination program for adult primary care and use the lessons learned from our Pediatric Medical Home program at UCLA, which has provided comprehensive care and care coordination for medically complex children, adolescents and young adults since 2003, in order to provide complex case

management for high risk adult medical populations. Demonstrated elements of care coordination include risk stratification methodologies, patient-centered care plans, and transitions of care management.

We propose to leverage our experience in this setting, along with the existing infrastructure for adult chronic care management in primary care, to develop complex care management programs for at least one adult high-risk medical population. We also propose to better coordinate UCLA's strengths in specialty care for our adult high-risk medical patients, who need to manage multiple chronic conditions.

Steps in accomplishing this proposal include:

- Identification of target practice and population by DY11
- Identification and training of initial cohort of care coordinators by DY11,
- Establishment of patient registries by DY11, including identification of eligible patients utilizing qualitative and quantitative methods
- Establishing the capability for longitudinal monitoring of relevant metrics for enrolled patients, including hospitalization and ED visit rates by DY12

Description of Pediatric Medical Home

1. Scope of the Program

The Pediatric Medical Home Program at UCLA, one of the first comprehensive programs for medically complex children built explicitly around the American Academy of Pediatrics' medical home model and integrated into a primary care clinic, was initially developed in 2003 with funding from the Healthy Tomorrows Partnership for Children, a program jointly sponsored by the American Academy of Pediatrics and the Maternal and Child Health Bureau. The initial goals of the program included 1) to implement a primary care coordination program within our Pediatric Resident Continuity clinic for the most medically complex children; 2) to build a pediatric resident physician training curriculum to care for children with complex chronic conditions based on medical home principles and best practices; and 3) to foster pediatric medical home health services research.

The program focuses on one of the most vulnerable segments of our community—children from low-income families who have serious chronic medical conditions. These families frequently face significant challenges in accessing health care, administering medications, and balancing the multiple needs of the family and special needs child. These challenges are frequently compounded by racial, economic, cultural, linguistic and educational barriers. The Medical Home allows them to receive better care while conserving limited health care resources. Current enrollment criteria include any primary care pediatric patient having at least two conditions which make them eligible for two distinct subspecialty care centers as defined by eligibility criteria for California's Title V program for CSHCNs, California Children's Services (CCS). Approximately 250 patients are enrolled in the program, nearly all with public insurance, and approximately 70 percent self-identifying as Hispanic.

The program is currently staffed by 4 part-time pediatricians, a nurse practitioner, and 3 full-time bilingual family liaisons. The family liaisons attend appointments, provide translation services, and coordinate follow up appointments, procedures, and other clinical needs such as obtaining durable medical equipment, insurance authorizations, and communication with community services including the school system. Additional program components include a formal comprehensive patient intake process incorporating a "social contract" with the parents, individualized patient information ("All About Me") binder, longer follow-up visits, care coordination assistance, ongoing quality improvement through organized evaluations research, and a Parent Advisory Group that meets bimonthly.

Program outcomes

Evaluation of this program for the initial cohort of patients found that the number of emergency department visits per patient decreased by over 50% after enrollment in the program (Klitzner TS, Rabbitt LA, Chang RR. Benefits of Care Coordination for Children with Complex Disease: A Pilot Medical Home Project in a Resident Teaching Clinic. *J Pediatr*. 2010 Jun; 156 (6): 1006-10). The program has achieved high parental satisfaction, particularly among Spanish-speaking families. (Hamilton LJ, Lerner CF, Presson AP, Klitzner TS. Effects of a Medical Home Program for Children with Special Health Care Needs on Parental Perceptions of Care in an Ethnically Diverse Patient Population. *Matern Child Health J.* 2012 May 9). Additional manuscripts related to program effectiveness are in preparation.

The Pediatric Medical Home Program incorporates a vibrant quality improvement program. A range of metrics are closely tracked and reviewed at monthly meetings. For example, hospitalization rates and ED visit rates are monitored via control charts, using patients on the waiting list for Medical Home enrollments to provide baseline comparisons (Table 1).

Table 1: Rate of encounters per 1000 patients per year, 2013

	Hospitalization rate	**ED visit rate**	**Readmission rate**	**Specialist visit rate**	**PCP visit rate**
Medical Home (n = 213)	0.83	0.95	0.19	5.62	4.23
Wait list (n = 40)	1.82	2.17	0.33	6.52	3.05

2. *Target Population:* While UCLA has care coordinators for adult primary care, we have not yet had specialty-based care coordinators whose explicit focus is on complex

care management for high-risk medical populations. Our proposed expansion with this focus, combined with our lessons learned with our pediatric and young adult populations, will improve care processes, health outcomes, and overall care value for our most vulnerable patients.

Vision for Care Delivery: UCLA has successfully implemented a primary care strategy for care coordination. This project will build on that infrastructure to focus systematic attention and resources to those with high medical complexity. We anticipate that this new emphasis on the highest utilizers has the greatest potential for value, improving quality while reducing overutilization of health care resources. We have successfully demonstrated the value of this approach in our system with pediatric and young adult populations; our pediatric medical home program has been shown to decrease hospitalization rates by 60%, readmissions rates by 25%, and ED visit rates by 50% in this very high utilizing population, while achieving high rates of patient satisfaction.

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.
Not 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.
Not Applicable	**2.3.4** Conduct a qualitative assessment of high-risk, high-utilizing patients.
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.

Check, if applicable	Description of Core Components
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.
Not 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.
Not 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.

☒ 2.7 – Comprehensive Advanced Illness Planning and Care

1. Complexity of illness, availability of advanced treatments and the drive toward advancement create a need for structures and training to promulgate advance care planning (ACP) to enhance the match of treatments with patient prognosis and goals, and ensure timely palliative care. UCLA Health proposes to expand and intensify its ACP model, which is a Let's Get Healthy California innovation, to maximize health outcomes for UCLA patients by promoting ACP processes reproducible across clinicians so that iterative information sharing and decision-making occur over time and

across care venues. The model integrates with the UCLA electronic health record so that patient preferences are elicited, preserved and iteratively updated in a fashion that will inform all providers and ensure that care decisions incorporate patients' goals and preferences. This model will be coupled with expansion of palliative care in the inpatient, outpatient and ambulatory settings. Guided by a multidisciplinary team of stakeholders, this project will meet the Prime Goals/Objectives by implementing the following.

- **Standardized ACP process and materials** trigger discussions based on patient condition, readiness to engage and immediacy of need. For patients with advanced disease, the program cultivates prognostic awareness to facilitate consideration of future health states and integrates supportive care. Roll out will meet patients' needs including embedding facilitators in teams caring for the sickest patients (e.g., outpatient oncology, inpatient heart transplant), training teams caring for advanced illness patients and implementing broad staff education.
- **Facilitated ACP in primary care** employing specially-trained unlicensed care coordinators stimulating ACP for medium and high risk patients to jumpstart the process for PCP completion, including completion of POLST.
- **POLST implementation** for patients with inpatient DNR orders using EHR triggers. Plans to participate in POLST Registry.
- **Metrics,** process and outcome, to evaluate ACP activities and drive quality improvement, including denominators to match targeted patients and outcome assessment surveys.

2. *Target Population*: The target population includes those in the PRIME eligible population who have stage 4 cancer or advanced organ failure. We have constructed EHR-based mechanisms to identify advanced illness populations for cancer, dementia, ESRD and heart failure, and in this project will complete the denominators for ESLD, Stage IV COPD and Neurodegenerative disease. An Advance Care Planning Dashboard of process and outcome metrics has been created that can be applied to each of these advanced illness patient groups, and we are creating a denominator of a serious, chronic illness primary care population to target for ACP. We anticipate that only a subset of our target population will require referral for specialty palliative care services, but we will build infrastructure and primary care team capacity to conduct ACP and provide or refer to supportive care for the full target population.
The target population are those individuals in the

1) PRIME Eligible Population AND
2) AND has a Stage 4 Cancer OR
3) "OR Advanced end organ failure (any of the following:
   - ESRD in pts > 80 yo
   - ESLD (MELD Score ≥30)
   - Class IV CHF
   - Stage IV COPD
   - Advanced dementia (CDR 3)
   - Neurodegenerative disease who are non-ambulatory"

This target population is most in need of sensitive, cohesive care. Only 20 percent of potentially appropriate patients have access to community-based palliative care services, outlined in the MC2020 PRIME Attachment Q.

Therefore, to ensure access to comprehensive care in alignment with patient preferences for patients facing advanced illness (i.e. in the target population defined above) we selected core components we feel would fill this need.
Vision for Care Delivery: UCLA will improve ACP and palliative care for the Project 2.7 Target Population by identifying advanced illness patients and conducting training for clinicians that is tailored to these patients' needs. Within the overarching ACP model, specific interventions and materials match the needs of particular patient groups (e.g., patients with advanced heart failure awaiting transplant). We plan to develop a dedicated ACP EHR module that not only preserves goals of care conversations and advance directives and POLSTs, but also highlights unmet need and prompts ACP intervention by trained staff so that informed goals guide care decisions and preferences transition with patients between venues of care.

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

Check, if applicable	Description of Core Components
Applicable	**2.7.1** Establish or expand both ambulatory and inpatient palliative care (PC) programs that provide: • Total, active and individualized patient care, including comprehensive assessment, inter-professional care planning and care delivery. • Support for the family. • Interdisciplinary teamwork. • Effective communication (culturally and linguistically appropriate). • Effective coordination. • Attention to quality of life and reduction of symptom burden. • Engagement of patients and families in the design and implementation of the program.
Applicable	**2.7.2** Develop criteria for program inclusion based on quantitative and qualitative data: • Establish data analytics systems to capture program inclusion criteria data elements.
Applicable	**2.7.3** Implement, expand, or link with, a Primary Palliative Care training program for front-line clinicians to receive basic PC training, including advanced care planning, as well as supervision from specialty PC clinicians. Assure key palliative care competencies for primary care providers by mandating a minimum of 8 hours of training for front line clinicians in communication skills and symptom management.

Check, if applicable	Description of Core Components
Applicable	**2.7.4** Develop comprehensive advance care planning processes and improve implementation of advance care planning with advanced illness patients.
Applicable	**2.7.5** Establish care goals consistent with patient and family preferences, and develop protocols for management/control of pain and other symptoms in patients with advanced illness, including a holistic approach that includes spiritual and emotional needs.
Applicable	**2.7.6** Improve completion of Physician Orders for Life-Sustaining Treatment (POLST) with eligible patients and participate in the state-wide POLST registry.
Not Applicable	**2.7.7** Provide access to clinical psychologist on the palliative care team to address psychological needs of patient and the family members during the advanced illness and provide grief counseling and support to the family after death of their loved ones.
Not Applicable	**2.7.8** Enable concurrent access to hospice and curative-intent treatment, including coordination between the providing services.
Not Applicable	**2.7.9** Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice, including linkage with PC training program.
Not Applicable	**2.7.10** For advanced illness patients transitioning between primary care, hospital, skilled nursing facilities (SNFs), and/or home-based environments, ensure that the advance care plan is clearly documented in the medical record and transmitted in a timely manner to the receiving facilities and care partners who do not have access to the health system's medical record.
Applicable	**2.7.11** Engage staff in trainings to increase role-appropriate competence in palliative care skills, with an emphasis on communication skills.
Applicable	**2.7.12** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

Please complete the summary chart:

	For DPHs	For DMPHs
Domain 2 Subtotal # of DPH-Required Projects:	**3**	**0**
Domain 2 Subtotal # of Optional Projects (Select At Least 1):	**1**	
Domain 2 Total # of Projects:	**4**	

Section 4.3 – Domain 3: Resource Utilization Efficiency

☒ 3.3 – Resource Stewardship: Therapies Involving High Cost Pharmaceuticals

1. We selected this project because pharmaceuticals account for roughly 15% of the total cost of care per year. In addition, pharmaceutical costs are increasing at a pace of roughly 10% each year. For over a decade, UCLA Health has managed pharmaceutical costs on a population basis for our risk-based HMO contacts. We plan to expand this activity to encompass other patient populations by developing an expanded multidisciplinary pharmaceutical use team that will focus on evidence based guidelines and enablement of appropriate clinical pathway design, and provide feedback to providers. We will also focus on generic substitution opportunities. We will focus whenever possible on optimizing our EMR to enable these outcomes.
Our project will improve care by ensuring that pharmaceuticals, in particular higher cost pharmaceuticals, are used when appropriate and not used when not appropriate and that evidence-based decisions are made.

This project will enable UCLA to extend our existing pharmacy based innovations to our outpatient setting, creating a system-wide strategy for our patients. Specifically, we will engage both inpatient and outpatient providers in order to:

- Organize the approach of our medication management teams and relevant internal resources (e.g. informaticists, clinical specialists) to plan, evaluate, and develop the use of decision support/CPOE,

- Monitor indications of use for high cost pharmaceuticals for evidence-based guidelines and medical criteria to support established standards.

2. *Target Population:* The target population includes those in the PRIME eligible population who are currently an inpatient at either hospital in the Health System, and those individuals who are seen by a primary care team member. The target population

definitions and specifications will be followed as set forth by the CAPH/SNI measure specifications manual for Project 3.3. As of May 23, 2016 this includes the combination of both Population #1 and Population #2 OR individuals with any acute care utilization at the PRIME entity during the measurement period.

Vision for Care Delivery: UCLA will improve the care for the Project 3.3 Target Population by identifying behaviors that lead to inappropriate therapy and intervening to ensure pharmaceuticals are used appropriately. These interventions include guidelines, audit and feedback, limiting the availability of high-cost and/or highly abused drugs. Specifically, we plan to leverage existing IT infrastructure to optimize antimicrobial use, for example inclusion of a clinical indication in the EHR as a hard stop for clinicians at the point of ordering.

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

Check, if applicable	Description of Core Components
Not Applicable	**3.3.1** Implement or expand a high-cost pharmaceuticals management program.
Applicable	**3.3.2** Implement a multidisciplinary pharmaceuticals stewardship team.
Not Applicable	**3.3.3** Develop a data analytics process to identify the participating PRIME entity highest cost pharmaceuticals (high-cost medications or moderate-cost meds with high prescribing volume). Identify high-cost medications whose efficacy is significantly greater than available lower cost medications. • Using purchase price data, identify the top 20 medications and medication classes, focusing on the following: Analgesics, Anesthetics, Anticoagulants, Anti-Neoplastics, Diabetes, Hepatitis C, Immunoglobulins, Mental Health (Anti-Depressants/Sedatives/ Anti-Psychotics), Respiratory (COPD/Asthma), Rheumatoid Arthritis. o Exclude Anti-Infectives and Blood Products (addressed in separate PRIME Projects). o
Not Applicable	**3.3.4** Develop processes for evaluating impact of high-cost, high-efficacy drugs, particularly drugs to treat conditions (e.g., HCV) or to address circumstances (e.g., oral anticoagulants for patients without transportation for blood checks) more prevalent in safety net populations: • Consider criteria that include ability of identified medications to improve patient health, improve patient function and reduce use of health care services.

Check, if applicable	Description of Core Components
Applicable	**3.3.5** Develop processes to impact prescribing by providers by establishing standards of care regarding prescribing of high cost pharmaceuticals, including: • Use of decision support/CPOE, evidence-based guidelines and medical criteria to support established standards. • Develop processes to improve the appropriate setting for medication delivery including, transitioning pharmaceutical treatment to the outpatient setting wherever possible. • Promote standards for generic prescribing. • Promote standards for utilizing therapeutic interchange.
Applicable	**3.3.6** Improve the process for proper billing of medications, through clinician education and decision support processes.
Not Applicable	**3.3.7** Develop formulary alignment with local health plans.
Not Applicable	**3.3.8** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership rapid cycle improvement using standard process improvement methodology.
Not Applicable	**3.3.9** Develop organization-wide provider level dashboards to track prescribing patterns for targeted high cost pharmaceuticals. Dashboard to include comparisons to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.
Not Applicable	**3.3.10** Develop processes for working with providers with prescribing patterns outside established standards, to identify and reduce barriers to meeting prescribing standards: • Develop guidelines and provide staff training on methods for engaging patients in shared decision making for developing treatment plans within the context of the established standards.
Not Applicable	**3.3.11** Maximize access to 340b pricing: • Share templates for contracting with external pharmacies. To improve program integrity, share tools for monitoring of 340b contract compliance.

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 $ 26,121,200
- DY 12 $ 26,121,200
- DY 13 $ 26,121,200
- DY 14 $ 23,509,080
- DY 15 $ 19,982,718

Total 5-year prime plan incentive amount: $ 121,855,398

Section 9: Health Plan Contract (DPHs Only)

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

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

Section 10: Certification

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

Appendix- Infrastructure Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
1.				
2.				
3.				
4.				
5.				