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

Riverside University Health System

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.

Riverside University Health System (RUHS) resides in Riverside County (Table 1), ranking 29th of 57 counties for health outcomes.[1]

Physical Health:

- Diabetes/Obesity: The prevalence of diagnosed adult Type 2 diabetes is 7.4% (California: 6.9%). Obesity, a key risk factor for diabetes, has a prevalence of 25.9%.[2]

- Hypertension: Hypertension prevalence among adults is 33%. The Emergency Department (ED) adult visit rate for hypertension is 29.6, below the 25th percentile (23.6) when compared to other California counties.[3]

- Heart Disease: Heart disease accounts for 27% of county deaths.[4] Riverside County has a higher age-adjusted mortality rate for heart disease, ranking 52 out of 58 counties.[5]

***Behavioral Health*:** The percentage of adult residents needing care for behavioral health or substance abuse issues and obtained help in the past year is 57%.[6] See Table 2 for the most common diagnoses for adults treated by RUHS-Behavioral Health.[7]

Health Disparities: African Americans and Hispanics are disproportionately affected by chronic conditions (see Tables 3 and 4).[8] Hispanics in the Coachella Valley are more likely to have health care access issues and more likely to report "fair" or "poor" health compared to White adults (24% vs. 13%, respectively).[9]

Coverage: There are nearly 635,000 Medi-Cal beneficiaries in the county, almost doubling since 2014. [10]

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.

Riverside County is the fourth largest county in California with nearly 2.4 million residents. It also ranks as the sixth fastest growing county.[11] Significant growth occurred between 2000-2010 when the population increased by nearly 635,000 people or 41% (Table 5)[12]. Riverside County encompasses over 7,200 miles and is similar in size to the state of New Jersey.

Income: Riverside County's per capita income is $23,660 which is over 20% below California's average. The median household income is $56,592, nearly 9% below California's median income. The percentage of individuals living in poverty is 17%.[13]

Age: Riverside County's population is slightly younger with a median age of 35 compared to California (36). The population under 18 years is 26%, about 10% more than California's average. Those 18-64 years of age comprise 61% of the population while seniors 65+ represent 13% of the population (Table 6).[14]

Race/Ethnicity: Riverside County has a diverse population where nearly half of the residents are Hispanic (48%), somewhat higher than California's average (39%). Whites comprise 37% of the population, followed by African Americans (7%), Asians/Pacific Islanders (7%), and American Indians/Alaska Natives (1%) (Table 7).[15]

Language: About 60% of the population speaks only English at home. An additional 40% speak another language at home, with the majority speaking Spanish.[16]

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.

Riverside University Health System (RUHS) is comprised of RUHS – Medical Center, RUHS – Care Clinics, RUHS – Public Health, and RUHS – Behavioral Health. The system was created in 2015 through a merger of separate county departments with the goal of becoming a clinically integrated network to better serve the health care needs of Riverside County residents. RUHS has affiliations with several medical schools: Loma Linda University Medical Center, University of California-Riverside, and Western University of Health Sciences.

The Medical Center, formally known as Riverside County Regional Medical Center, is a licensed 439-bed general acute care hospital located in Moreno Valley. There are 225 general acute care beds, 44 intensive care beds, 40 perinatal beds, 32 intensive care newborn nursery beds, and 21 pediatric beds. There are also 77 acute psychiatric beds at the Arlington Campus in the city of Riverside. The Medical Center is a Level II trauma center and primary stroke center certified by The Joint Commission and has the only pediatric intensive care unit in the region. Based on gross revenue, the payer mix is predominantly Medi-Cal (57%), followed by third party payers (22%), Medicare (17%), and indigent/other payers (4%) (Table 8).[17]

There are 70 primary and specialty care clinics located on the Moreno Valley campus, plus 10 Federally Qualified Health Centers (FQHCs) geographically dispersed throughout Riverside County providing primary care services.

RUHS – Public Health provides services including nutrition, family planning, and immunizations. RUHS-Behavioral Health offers services, including crisis intervention, psychiatric assessments, case management, and substance abuse programs.

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.

RUHS currently has challenges to collect, report, and monitor performance data because it does not have an integrated electronic health record (EHR). There is one system for hospital inpatient services and a separate system for the hospital-based clinics which only the four primary care clinics use. The remaining clinics all use paper charts. To support the development of an integrated delivery system, RUHS will be launching the EPIC EHR in August 2016 for the FQHC clinics and October 2016 for the hospital and hospital-based clinics.

In addition, RUHS currently lacks a data analytics team. To address this issue in the short-term, two full-time data analysts are being recruited to join the hospital statistician in collecting, analyzing, and validating PRIME data. There is also a plan to establish an integrated data analytics team to address quality and financial performance metrics.

Data Collection: For DY 11, information will be collected from multiple data systems, including the current EHRs, financial/registration systems, paper logs, outside lab data systems, and manual chart abstraction. Information will also be collected from the Medi-Cal managed care plans with whom we partner. In DY 12 RUHS will rely on a hybrid approach – part electronic, part paper – to obtain the data. In DY 13 and beyond RUHS should be collecting 100% of the data electronically.
Reporting: RUHS uses a limited number of dashboards, given our fragmented data systems, to track performance. With the transition to EPIC, more robust dashboards will be implemented to track performance on PRIME metrics as well as on other quality indicators.

Monitoring: The hospital statistician and new data analysts will generate dashboards and indicate potential performance issues that need to be addressed. Clinicians and managers, assisted by performance improvement professionals to be hired, will implement strategies to address and resolve identified performance issues.

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.*

   RUHS's 5-year PRIME goals are:

   - Goal #1: Provide timely, patient-centered, whole person care so patients receive the right care at the right time and place that is sensitive to the individual's needs and social context.
   - Goal #2: Develop a highly integrated and coordinated system of care reinforced by care management teams.
   - Goal #3: Promote cost-effective population health management to improve quality and reduce cost.

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.*

   To achieve Goal #1, RUHS will establish a foundation of medical homes. It will also integrate physical and behavioral health services at a system level. Goal #2 will be achieved by enhancing communication across service lines and settings. Complex care management teams will also be implemented. To

achieve Goal #3, workflows will be standardized and evidence-based practices will be adopted. Quality will be improved and costs will be reduced.

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;*

The Primary Care Redesign, Behavioral Health Integration, and Chronic Pain projects will support Goal #1. The Primary Care Redesign project will reinforce efforts to create medical homes by improving empanelment and building medical home teams that have continuous healing relationships with their patients. The Behavioral Health Integration and Chronic Pain projects will support providing holistic care by expanding the multidisciplinary care team to include behavioral health specialists.

The Specialty Care Redesign, Perinatal Care, and Transitions of Care projects will support Goal #2. These projects will strengthen communication across service lines and settings by creating standardized referral workflows and communication protocols. The Specialty Care Redesign and Transitions of Care projects will contribute to implementing complex care management teams by developing new care coordinator and care manager positions that will serve as “system integrators.”

The Million Hearts, Complex Care, and High Cost Pharmaceuticals projects support Goal #3. The Complex Care and High Cost Pharmaceuticals projects both seek to improve quality and reduce cost through the use of risk stratification, proactive management, and robust data analytics. Similarly, the Million Hearts and High Cost Pharmaceuticals projects both reinforce standardizing workflow and adopting evidence-based practices by utilizing the EHR as a tool for best practice and by sharing performance feedback at an individual provider level.

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).*

Many of the PRIME projects will inter-relate to achieve system transformation. The Behavioral Health Integration and Chronic Pain projects inspire patient-centered whole person care that is critical for improved patient experience. The Complex Care and High Cost Pharmaceuticals projects employ risk stratification and standardized cost-sensitive practices that are necessary for

successful population health management. The Primary Care Redesign and Specialty Care Redesign projects focus on constructing a highly efficient, proactive, and collaborative outpatient delivery care network that serves as the foundation for an accountable health system. The Perinatal Care and Transitions of Care projects build seamless bridges between care settings and encourage proactive outpatient interventions to move care upstream and reduce total costs.

All PRIME projects will be inter-connected and grounded via a novel network of outpatient care site-based integrated complex care management teams. Each team will consist of a care manager, care coordinator, and behavioral health specialist. It will serve to not only integrate PRIME project efforts at a medical home team level, but will also help to integrate and sustain PRIME initiatives at a system level, thereby enabling true transformation.

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.*

RUHS will be recognized as a leader in delivering high quality, service-oriented, seamlessly coordinated care. It will be well positioned to manage clinical outcomes and cost in order to assume and manage risk for populations and participate in alternative payment methodologies. RUHS will be a successful organization known for providing care that is innovative, patient-centered, and whole person-oriented in a way that drives interventions upstream to improve overall quality while reducing overall costs.

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 discussed in Section 2.1, Riverside County's population has chronic health care needs, including diabetes, obesity, hypertension, and heart disease. RUHS has selected projects, including Ambulatory Care Design-Primary Care (1.2) and Million Hearts Initiative (1.5), to address these needs by developing standardized workflows in all RUHS primary care clinics to more proactively conduct preventive health screenings to identify at-risk individuals for chronic conditions and provide earlier intervention services. These services would also address the patient's risk factors for developing such conditions, including tobacco usage and dietary/obesity issues. Our goal is to reduce unnecessary ED visits and preventable admissions. With our transition to another, more integrated EHR this year, we will develop a data analytics capability to better collect and stratify data on the patients we serve, including by race/ethnicity and sexual orientation/gender identify, to better address their health care needs.

Behavioral health services is another critical need. We currently have a fragmented system to meet the whole person care needs of our patient population. Through our Behavioral Health and Primary Care Integration (1.1), Care Transitions (2.2), and Complex Care Management (2.3) projects, enhanced care integration will be advanced through establishment of a comprehensive care management strategy, including placement of care teams (care coordinator, case manager, behavioral health specialist) in RUHS clinics to provide standardized screenings to promote the earlier detection of patients needing behavioral health services while addressing their physical health needs. The care team will assist patients in navigating the RUHS system which should increase patient experience.

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).

The PRIME program is closely aligned with RUHS's strategic initiatives, especially those pertaining to:

- Development of an integrated delivery network, including the hospital, hospital-based clinics, and FQHC clinics

- Provision of patient-focused care
- Development of a population health management program
- Integration of internal systems, including the EHR and other support systems
- Achievement of operational excellence, including financial performance, productivity goals, employee engagement and quality and safety goals

PRIME program planning has been included in RUHS's strategic planning retreats where a dedicated work group comprised of management and physician leadership has been developing a comprehensive work plan that encompasses the identification of resources needed to support PRIME's successful implementation. In addition, each PRIME project has been assigned a team which will have responsibility for implementing the project's core components and achieving the metrics' performance targets. These teams will each include a project lead and clinical champion in addition to other staff and clinicians as appropriate. Some teams may also include representatives from other county departments, such as behavioral health.

The Lean methodology being implemented will assist RUHS in the attainment of quality goals and PRIME metric targets through changes in workflows and processes that support performance improvement. The launching of a new integrated EHR in the hospital and all ambulatory clinics will provide RUHS the ability to establish robust dashboards and other monitoring/feedback systems to support performance improvement and data-driven decisions.

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.

RUHS is developing multiple strategies for engaging stakeholders in PRIME program planning and implementation. Regular focus groups are conducted with Family Care Clinic patients. The establishment of a pain management support group, as recommended by patients, will align with our Chronic Non-Malignant Pain Management PRIME project.

Leadership from our primary Medi-Cal managed care plan is another key stakeholder and strategic partner who has been participating in discussions around PRIME projects. RUHS is participating in a combined behavioral health/primary care integration and care management project with this health plan. The project's design will be closely aligned with three PRIME projects, including 1.1 Integration of Behavioral Health and Primary Care, 2.2 Care Transitions: Integration of Post-Acute Care, and 2.3 Complex Care Management for High Risk Medical Populations.

Future strategies to engage stakeholders may include the FQHC board's more direct involvement in PRIME program planning and implementation, development of a patient advisory council, and the addition of a patient representative to the hospital's Ambulatory Care Committee. The new director of population health has been actively working with various agencies and community organizations to identify the county's critical health needs. Through her outreach these organizations will provide input on the PRIME program.

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.

RUHS has committed to enhancing the experience of individuals representing different cultures and backgrounds seeking care at our health system. In 2007 a real-time health care interpreters program was launched, providing interpreters for over 170 languages, plus American Sign Language. This service is available on a 24/7 basis. In addition, three video relay service devices are available to communicate with the deaf and hearing impaired. Educational materials are provided to patients in their preferred language which is primarily English and Spanish. Bilingual staff and providers are also recruited to supplement the interpreter services program. Cultural diversity training is also provided at new employee orientation.

Building on this foundational work, RUHS will continue efforts to ensure the needs of our patient population will be met. To reduce disparities, the mobile health clinic will continue providing primary care services to low income individuals in areas of greatest need throughout the county. The director of the recently formed Department of Population Health is collecting data to quantify existing health disparities so reduction goals can be established. RUHS is also sensitive to current disparities among individuals needing behavior health services, so this area will also be a major focus.

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.

RUHS Executive Leadership has committed to providing the necessary resources to implement a comprehensive quality improvement program, based on Lean methodology. RUHS will work with Lean Healthcare Associates (LHCA) to roll out this program over the next year.

- ***Training***: LHCA will provide institution-wide training on topics, including Lean methodology, communication, and teamwork. More targeted Lean education will be provided to hospital and ambulatory care leadership so they have the knowledge and tools to implement and sustain change in their areas.

- ***Staffing***: RUHS is hiring two performance improvement staff with responsibility for reinforcing Lean throughout the organization. Dedicated teams will be appointed to work on quality outcomes and patient care projects.

- ***Areas of Focus:*** The initial focus will be in the clinics, including development of standardized workflows and performance score cards and revising scheduling procedures. At the hospital the focus will include launching a patient experience program and improving patient throughput.

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)

This project expands upon a pilot behavioral/physical health co-location project that RUHS initiated in 2011. In Riverside County the physical health care system is disconnected from the behavioral health care system, resulting in poor quality of care and health outcomes, plus high costs. Inadequately treated behavioral and/or physical health conditions can negatively impact each other. Only by addressing both in an integrated fashion will RUHS patients receive optimal care.

This PRIME project is designed to accomplish:

1. Whole person care, resulting in improved patient and health care team experience.
2. Care coordination and integration of primary, specialty, addiction and behavioral health care across and between healthcare/treatment settings.
3. Complex care management of individuals with chronic conditions.
4. Population health management supported by data analytics and performance improvement.

5. Enhanced access for patients with co-existing physical and behavioral health conditions.

Our planned approach to implementation includes:

- ***Assessment Tool***: The current standardized screening tool will be revised to ensure its usefulness to providers and patients. It screens for major depression, substance abuse, and chronic physical health conditions.

- ***Behavioral Health Integration (BHI) Teams***: Triad teams will be implemented at each clinic consisting of a behavioral health specialist, care coordinator, and care manager. The behavioral health specialist will screen patients with standardized behavioral health screening tools and provide clinical therapy for appropriate patients. Care coordinators will manage care across providers, including tracking and follow up activities, to ensure patients receive patient-centered, whole person services at the right time and place. Care managers will assist patients with more complicated medical needs.

- ***BHI Training***: Education will be provided including: assessment, care planning and coordination, health coaching and motivational interviewing, Plan-Do-Study-Act Cycle, and team care evidence-based practice. Training will also be provided to all clinic staff and providers that will be interfacing with BHI team members.

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

- ***Target Population***. The target population will include patients who have both a chronic medical condition AND a mental health disorder or substance use disorder. Behavioral health, substance and addictive disorder assessment screenings of the target population will include adult patients, and pediatric patients as supported by evidence. Three primary care clinic sites will serve as pilot sites for physical health and behavioral health integration with anticipated rapid spread to all RUHS primary care and specialty care clinic sites.

- ***Vision for Care Delivery***: PRIME will enable RUHS to transform its current delivery system into an integrated, well-coordinated system that utilizes physical and behavioral health data for quality improvement and evaluation. This transformation will make possible the development of:

    - Complex care management systems for individuals with co-existing physical health and behavioral health conditions.

- A seamless experience of whole person care for all individuals that is patient-centered, cost effective, and results in improved health and wellness.

- Patient-focused, data-driven, team-based care and decision-making orchestrated collectively to ensure that a patient's full range of health care needs are met.

- Improved access for individuals with co-existing physical health and behavioral health conditions.

- Development, spread, and sustainability of medical homes.

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

Check, if applicable	Description of Core Components
Applicable	**1.1.1** Implement a behavioral health integration assessment tool (baseline and annual progress measurement)
Not Applicable	**1.1.2** Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration, the Collaborative Care Model, or other Integrated Behavioral Health (IBH) resources from SAMHSA)
Not Applicable	**1.1.3** Integrate appropriate screening tools and decision support into the emergency department (ED) to ensure timely recognition of patients with mental health and substance use disorder problems. Enhanced access to primary care and/or to behavioral health specialists will be integrated into discharge planning for these patents. Use of 24-7 care navigators (e.g., Community Physician Liaison Program) may be used to support linkages to primary care providers (PCPs), mental health (MH) and substance use disorder (SUD) specialists and behavioral health and other community services through the discharge process.
Applicable	**1.1.4** Integrate physical and behavioral health, either through implementation of a new program or an expansion of an existing program, from pilot sites to hospital and health system primary care sites or from single populations to multiple populations (e.g., obesity, diabetes, maternal, infant, and child care, end-of-life care, chronic pain management).

Check, if applicable	Description of Core Components
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.
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.

Check, if applicable	Description of Core Components
Not Applicable	**1.1.11** Ensure a culturally and linguistically appropriate treatment plan by assigning peer providers or other frontline worker to the care team to assist with care navigation, treatment plan development and adherence.
Not Applicable	**1.1.12** Ensure that the treatment plan: • Is maintained in a single shared Electronic Health Record (EHR)/ clinical record that is accessible across the treatment team to ensure coordination of care planning. • Outcomes are evaluated and monitored for quality and safety for each patient.
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)

RUHS recognizes the need to transform delivery of care to meet growing service demand with the continued primary care provider shortage in the Inland Empire. Therefore, RUHS's clinics must change the traditional approach to ambulatory care and shift focus towards team-based care and transition to patient-centered medical homes. We can then better leverage our resources towards robust population management and proactive care coordination with the goal to improve patient satisfaction, quality of care, and overall efficiency.

Our implementation approach includes:

- ***Patient-Centered Medical Homes (PCMH)****:* Our Family Care Clinic has achieved National Committee on Quality Assurance (NCQA) PCMH Level II recognition. Assessments have been completed for PCMH readiness at our remaining primary care clinics. Next steps include a gap analysis, create system-wide teams to address and bridge gaps in readiness, standardize workflows, implement evidence-based preventive and chronic disease processes, and work towards changes to achieve medical home status. With a new EHR being implemented later this year, we anticipate applying for PCMH recognition for all of our primary care sites during the DY 13-14 year.

- ***Population Management:*** Robust empanelment will be a key component of both PCMH and population management. An empanelment team will be assembled and protocols will be developed so empanelment becomes an ongoing systematized process. Accurate clinical data and attribution of patient clinical data to responsible medical home teams will be critical for engaging staff and providers in the process.

- ***Care Coordination***: RUHS plans to identify, establish, and train care coordinators, case managers, behavioral specialists, and other qualified clinic staff to embed at each primary care site. This care coordination/care management team will partner with providers and staff to identify care gaps, work with high risk patients for complex care management, facilitate bi-directional communication for referrals, and support patients with behavioral health and whole person care needs.

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

- ***Target Population***: The target population will be a broad cross-section of patients of all ages, including managed care patients assigned to our system and non-managed care patients. They will have chronic conditions, often with complex medical needs, as well as patients with preventive health care needs or short-term medical issues. As we optimize empanelment and develop a data analytics capability, more robust data will be available to address health disparities through the collection of accurate race, ethnicity, and language data and sexual orientation/gender identity information.

- ***Vision for Care Delivery*****:** This PRIME project will help RUHS achieve several key transformational steps towards achieving high quality, evidence-based,

patient-centered care. Empanelment and population management will enhance engagement of patients, staff, and providers. It will also promote data-driven decision making at a medical home team level, clinic care management level, and RUHS system level. Having medical home team staff and providers working at the top of their licenses to provide care in a coordinated, synchronous, and effective way will ensure staff retention and satisfaction, reduce provider burn out, improve patient satisfaction, and improve the health of our overall population.

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

Check, if applicable	Description of Core Components
Applicable	**1.2.1** Conduct a gap analysis of practice sites within the DPH/DMPH system.
Applicable	**1.2.2** Primary care practices will demonstrate advancement of their PCMH transformation through the use of a nationally-recognized PCMH methodology.
Not 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.
Not 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.
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	**1.2.6** Enable prompt access to care by:

Check, if applicable	Description of Core Components
Applicable	• 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.
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.
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.

Check, if applicable	Description of Core Components
	• 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)

RUHS embraces this project because of the significant need to provide well-coordinated specialty services and whole person care to a population with increasing chronic needs. To meet the growing specialty needs of our population in a resource-sensitive manner, our specialty clinics must transform from a fragmented, in-person visit-driven, access-challenged sites to seamlessly coordinated, highly accessible, proactive, and patient-centered models of care.

Our planned implementation approach includes:

- ***Enhanced Specialty Care and Primary Care Communication***: Implementation of a system-wide EHR in DY 11 will move our specialty clinic paper-based charts to electronic charts. It will help unify inpatient and outpatient care and facilitate improved specialty care and primary care collaboration, including e-consults, co-management, and referral loop closures.

- ***Standardized Workflow***: We will implement standardized workflows across all specialty clinic sites to ensure consistent pre-visit planning, consistent population health screening, timely patient access, consistent post-procedure follow-up utilizing telephone visits, and effective bi-directional communication between referring providers and specialty providers. System-wide treatment protocols will also be adopted.

- ***Culture of Improvement, Engagement, and Innovation***: We will implement Improvement Science training for specialty clinic staff to create a culture of employee engagement, continuous performance improvement, and innovative

design around alternative visit types. We will also provide Change Management training for specialty clinic leadership to support implementation of alternative visit types. We will also develop a shared need and vision, plus solidify commitment from staff and providers prior to implementation.

- ***Complex Care Management Program Partnership***: This complex care program will help augment specialty care clinic sites with care managers, care coordinators, and behavioral health specialists. As we implement improved communication across service lines, standardize workflow, and stimulate culture change, we will partner closely with the complex care management team members to ensure coordination and synergy among the specialty redesign, complex care, and behavioral health integration projects.

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

- ***Target Population***: Our target population will include all patients seen and cared for by RUHS specialty care clinics, including Medi-Cal managed care and/or Medicare patients, and the medically indigent.

- ***Vision for Care Delivery***: The objectives outlined in the Specialty Care Redesign Initiative are essential components of our ability to provide coordinated quality care for our patients. Meeting the varied needs of our patients through effective and efficient collaboration among providers and addressing coordination of care issues will reduce preventable hospital admissions and reduce the need for hospital ED visits. An integrated EHR will be an essential component of bridging the communication gap among providers and will also facilitate improved access and communication with patients.

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

Check, if applicable	Description of Core Components
Not Applicable	**1.3.1** Develop a specialty care program that is broadly applied to the entire target population.
Not Applicable	**1.3.2** Conduct a gap analysis to assess need for specialty care including mental health and SUD services (analysis to include factors impacting ability to access specialty care), and the current and ideal state capacity

Check, if applicable	Description of Core Components
	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).
Not Applicable	**1.3.4** Engage primary care providers and local public health departments in development and implementation of specialty care model.
Not 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.
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.
Not Applicable	**1.3.10** Develop and implement standardized workflows for diversified care delivery strategies (e.g., shared medical visits, ancillary led services, population management, telemedicine services) to expand access and improve cost efficiency.
Not Applicable	**1.3.11** Adopt and follow treatment protocols mutually agreed upon across the delivery system.
Not Applicable	**1.3.12** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population management activities and care coordination/transitions of care. Ensure that timely, relevant, and actionable data are used to support patient engagement, PCP collaboration, and drive clinical, operational and strategic decisions

Check, if applicable	Description of Core Components
	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.
Not Applicable	**1.3.16** Implement population management strategies for patients in need of preventive services, with chronic conditions, or with recurring long term surveillance needs.
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).
Not Applicable	**1.3.18** Demonstrate engagement of patients in the design and implementation of the project.
Not 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.

☒ 1.5 – Million Hearts Initiative

RUHS selected this project because there are significant needs among our patient population to better manage their cardiovascular health. Currently, we do not have a systematic approach to actively screen for high blood pressure and develop follow up plans. Given the shortage of primary care physicians in our county and increased patient demand for services, it can be difficult for providers to stay abreast of their patients' preventive health care needs. PRIME presents us with the opportunity to implement an innovative approach to preventive care by aligning this project with 1.2 Ambulatory Care Redesign: Primary Care to improve patient outcomes.

Our planned implementation approach includes:

- ***Implement Standardized and Evidence-Based Stewardship***: The Million Hearts team, comprised of physicians, pharmacists and qualified healthcare professionals, will develop standardized, evidence-based practice guidelines, based on the U.S. Preventive Services Task Force or other organizations, to support healthcare professionals in reaching the project's clinical targets. Further, the team will implement strategies to assess the quality of performance and adjust approaches accordingly.

- ***Develop Methodology in EHR to Assist Best Practices****:* RUHS is switching to a new EHR system later this year. Best practice alerts and any necessary medical record templates will be established to assist clinicians in providing targeted preventive services. The new EHR will also support data analyses to evaluate performance for quality improvement and document patient receipt of preventive services.

- ***Establish Appropriate Care Team Training***: We will identify and assess existing processes for tobacco and high blood pressure screenings. Standardized workflows will be developed and training programs will be created to educate staff per their scope of practice. Further, universal patient educational materials will be identified and distributed to ensure consistent practices.

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

- ***Target Population****:* Based on the project's metrics, our target population will include the following patients:
  - Preventative services (high blood pressure screening and tobacco use and counseling): All adult patients

- Hypertension Control: Adult patients between 18-85 years of age diagnosed with hypertension
- Optimal Use of Aspirin or other Antithrombotic: Adult patients discharged with acute myocardial infarction (AMI) or ischemic vascular disease (IVD).

- ***Vision for Care Delivery****:* Implementing standardized, evidence-based stewardship will improve the standard of care and drive best practices. Utilizing certified electronic medical records will enhance the communications between healthcare professionals and assist quality improvement analysis. Proper care team training will improve population management and reduce gaps in receipt of care.

  We envision the Million Hearts team working very closely with the Ambulatory Care Redesign team as a subcommittee, especially in identifying strategies to reduce health disparities pertaining to preventive services. Health disparities will be addressed by: coordinating with the Ambulatory Care Redesign team to obtain baseline data and implement processes to increase patient access to preventative services. Continuous discussion and review between the two project teams will bring forth the strategies aimed at reducing disparities in care. Those strategies include items described in core components #2 and #5. Ultimately standardization improves quality of care and delivery which should reduce disparities in care. We feel this collaboration will have greater, more rapid impact and allow for meaningful process improvement.

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

Check, if applicable	Description of Core Components
Applicable	**1.5.1** Collect or use preexisting baseline data on receipt and use of targeted preventive services, including any associated disparities related to race, ethnicity or language need.
Applicable	**1.5.2** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to the US Preventive Services Task Force (USPSTF) A and B Recommendations.
Not Applicable	**1.5.3** Improve access to quality care and decrease disparities in the delivery of preventive services.

Check, if applicable	Description of Core Components
Not Applicable	**1.5.4** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
Applicable	**1.5.5** Adopt and use certified electronic health record systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population management approaches (e.g., in-reach, outreach) to reduce gaps in receipt of care.
Not Applicable	**1.5.6** Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.
Applicable	**1.5.7** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. • Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts.
Not Applicable	**1.5.8** Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.

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**	

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

☒ 2.1 – Improved Perinatal Care (required for DPHs)

RUHS will focus on performance improvement opportunities to advance the care currently provided.

Our implementation approach includes:

- ***Continued Membership in California Maternal Quality Care Collaborative (CMQCC)****:* We have adopted their postpartum hemorrhage toolbox to ensure the provision of best practices. We will also collaborate with them on pregnancy-induced hypertension, gestational diabetes, and ≤ 39 week deliveries to provide the highest standards of care. Interdisciplinary teams, including medical staff, will review current policies and practices to ensure care is provided at the highest standard.

- ***Baby-Friendly Designation****:* We will maintain our Baby-Friendly designation by complying with all standards, including exclusive breastfeeding. An assessment will be conducted from prenatal care to postpartum discharge on the education and follow up care provided to breastfeeding mothers. Lactation consultants and clinic breastfeeding instructors will review their practices to reinforce a standardized approach. Post-discharge telephone surveys will be also conducted to collect data on mothers who continue to exclusively breastfeed at six months.

- ***Decrease Primary Cesarean Sections:*** Current data and protocols will be evaluated, based on the adoption of the CMQCC toolkit, to identify strategies for decreasing primary cesarean section rates, thus ensuring RUHS meets the standards.

- ***Data Collection****:* Quality metric data collection practices will be evaluated to ensure data integrity. This assessment will assist in more accurately measuring our performance and identifying improvement opportunities. This evaluation will be a collaborative effort, involving staff from perinatal services, medical records coding department, and hospital registration.

- ***Interdisciplinary Team Training and Continuing Education:*** Training on program standards for all relevant staff, including OB/GYNs, anesthesiologists, residents, nursing staff, scrub technicians, ED staff, and code responders, will be conducted. It will include mock codes and debriefings related to this exercise.

Ongoing training will be provided to address identified issues or other topics as indicated.

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

- ***Target Population**:* The current target population, which is primarily high risk pregnant women, will continue to be the key focus. As RUHS expands its patient base, the target population could include a greater proportion of pregnant women who have little to no complications.

- ***Vision for Health Care Delivery**:* Participation in the PRIME project will lead to:

  - *Improved Outcomes*: Through an improved data collection process on quality metrics, improvement opportunities will be identified. An interdisciplinary team will analyze this information and make recommendations for change in workflows that can lead to improved patient outcomes. Training on these new processes will be provided to all relevant staff to reinforce their understanding of the new workflows and ensure their compliance.

  - *Improved Communication among Providers*: Through identified process improvement opportunities, greater communication between prenatal care clinics, mental health clinics, and incarcerated patients will result so our high risk patients have a plan in place prior to delivery. This plan can include using the right medications; neonatology consult and their presence at the delivery; and type of induction to be used and at what gestation to induce the due mother's condition. In addition, standardized protocols will be established by specific diagnoses pertaining to when patients should have their follow up visit post-delivery.

  - *Exclusive Breastfeeding:* With lactation consultants conducting patient follow up telephone surveys, patients will be better enabled to continue exclusive breastfeeding by receiving advice and/or being referred to community programs or support systems.

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).

Check, if applicable	Description of Core Components
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)

Our implementation approach includes:

- ***Development of Care Transitions Management Teams***: They will be established to improve the coordination and continuity of care provided to targeted patients. This infrastructure includes an inpatient care transitions team, a complex care management team, and transition navigators. The inpatient team will include case managers, discharge planners, social workers, pharmacists, bedside care givers, and physicians. The complex care management team includes medical home teams (primary care providers and outpatient care management staff). These teams will work with the health plan's care managers as applicable to coordinate the patient's care. Patients and family will also be actively engaged in their care plan throughout their stay.

- ***Data Collection***: We will collect utilization data, including readmission rates by diagnosis, to better define patient needs. Based on our analysis, we will establish clearly defined criteria for our target population. With RUHS's transition to a more robust EHR later this year, we will have the ability to stratify our targeted population on several levels, including by diagnosis, social needs, cultural factors, and language, to identify those at risk for readmission and to provide appropriate interventions.

- ***Development of Standardized Workflows***: Current practices, such as patient admission and discharge; pharmacy-driven patient education on medications; identification of patients' behavioral health, substance abuse, and social needs;

referrals to community resources; and patient hand-off between providers will be evaluated to identify opportunities for improvement and standardize workflows to improve care coordination and communication between providers.

- ***Standardized Tools***: To enhance care coordination, standardized tools will be created to collect information such as the patient's current medication list, living conditions, behavioral health and/or substance abuse issues, need for placement upon discharge, and availability of family support. Other tools to be developed include those that track readmission rates and other transitional care information to identify risk factors for readmission.

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

- ***Target Population***: Initially, our target population will include high-risk and/or high-cost patients. It may include patients with multiple chronic conditions with repeat admissions or multiple ED visits and/or patients with chronic physical conditions and co-existing behavioral health or substance abuse conditions. Additional criteria for the target population may expand to include other types of patients as we gather data during our implementation process.

- ***Vision for Care Delivery***: The CTM teams will coordinate the management of the patient's care, ensuring the smooth transition from acute to post-acute care settings. They will collaborate with primary care providers, community resources such as the Department of Public Health and Behavioral Health, home health and palliative care/hospice agencies, skilled nursing facilities, and health plans to address the medical, social, behavioral, and cultural conditions that predispose patients to decompensation and re-hospitalization. The complex care management team will also assist patients to develop skills in medication self-management and recognize red flags in their medical condition, plus schedule follow up appointments. Case managers will continue working with companies to ensure patients have the necessary equipment when they return home after hospital discharge. Transition navigators will provide post-acute telephone calls to verify patient safety, compliance with the care plan, and guidance to manage healthcare-related challenges. Overall, CTM teams will ensure increased communication and coordination between all providers involved in the patient's care plan which should help reduce preventable admissions and ED visits, resulting in decreased health care costs.

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

Check, if applicable	Description of Core Components
Not Applicable	**2.2.1** Develop a care transitions program or expand a care transitions program to additional settings (e.g., emergency department), or to additional populations, using or adapting at least one nationally recognized care transitions program methodology.
Applicable	**2.2.2** Establish or expand on a system to track and report readmission rates, timeliness of discharge summaries, and other transition processes, and investigate system-specific root causes/risk factors for readmission, using quantitative and qualitative information to identify the key causes of readmissions, including physical, behavioral and social factors.
Applicable	**2.2.3** Develop and implement a process, including utilization of data and information technology, to reliably identify hospitalized patients at high-risk for readmission.
Applicable	**2.2.4** Develop standardized workflows for inpatient discharge care: • Optimize hospital discharge planning and medication management for all hospitalized patients. • Implement structure for obtaining best possible medication history and for assessing medication reconciliation accuracy. • Develop and use standardized process for transitioning patients to sub-acute and long term care facilities. • Provide tiered, multi-disciplinary interventions according to level of risk: o Involve mental health, substance use, pharmacy and palliative care when possible. o Involve trained, enhanced IHSS workers when possible. o Develop standardized protocols for referral to and coordination with community behavioral health and social services (e.g., visiting nurses, home care services, housing, food, clothing and social support). Identify and train personnel to function as care navigators for carrying out these functions.
Not Applicable	**2.2.5** Inpatient and outpatient teams will collaboratively develop standardized transition workflows: • Develop mechanisms to support patients in establishing primary care for those without prior primary care affiliation. Develop process for warm hand-off from hospital to outpatient provider, including assignment of responsibility for follow-up of labs or studies still pending at the time of discharge.
Not Applicable	**2.2.6** Develop standardized workflows for post-discharge (outpatient) care: • Deliver timely access to primary and/or specialty care following a

Check, if applicable	Description of Core Components
	hospitalization. • Standardize post-hospital visits and include outpatient medication reconciliation.
Not Applicable	**2.2.7** Support patients and family caregivers in becoming more comfortable, competent and confident in self-management skills required after an acute hospitalization by providing: • Engagement of patients in the care planning process. • Pre-discharge patient and caregiver education and coaching. • Written transition care plan for patient and caregiver. • Timely communication and coordination with receiving practitioner. Community-based support for the patient and caregiver post hospitalization focusing on self-care requirements and follow-up care with primary and specialty care providers.
Not Applicable	**2.2.8** Engage with local health plans to develop transition of care protocols that ensure: coordination of care across physical health, substance use disorder and mental health spectrum will be supported; identification of and follow-up engagement with PCP is established; covered services including durable medical equipment (DME) will be readily available; and, a payment strategy for the transition of care services is in place.
Not Applicable	**2.2.9** Demonstrate engagement of patients in the design and implementation of the project.
Not 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)

RUHS is undertaking this project to build an integrative complex care management program that optimizes care for our high risk patient population while reducing

inappropriate high cost utilization.

Our planned approach to implementation includes:

- ***Care Management Program***: Develop an integrative complex care management program with a defined cohort consisting of patients with chronic physical health conditions and co-existing behavioral health or substance abuse conditions in order to improve overall quality and cost of care

- ***Care Management Teams***: As part of the integrative complex care management program, implement multidisciplinary care management teams at each of the RUHS primary care and specialty care sites (15 sites total with one team at each site). Each care management team will include a: care manager (registered nurse), care coordinator (medical assistant), and behavioral health specialist (licensed clinical social worker or clinical psychologist). The care manager will support patients with the most complicated medical needs and will focus on patients with frequent hospitalizations and high utilization. The care coordinator will assist with patient navigation, tracking, and outreach; and will serve as a liaison between service lines and settings. The behavioral health specialist will serve those with co-existing behavioral health needs. Care management teams will be piloted initially at three clinic sites and will be rapidly spread to all RUHS primary care and specialty care sites by DY12.

- ***High-Risk Population Identification and Data Analytics***: We will develop a data analytics system to identify, track, risk stratify, and manage our complex care population. In DY11, we will implement a new EHR that will significantly augment this effort. In addition to utilizing RUHS clinical and financial data, we will also incorporate health plan data (e.g., claims, risk adjustment factor scoring, etc.) to assist with high-risk population identification and monitoring.

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

- ***Target Population***: We will utilize the high-risk population identification and data analytics process to delineate the target population. The anticipated target population will include patients with chronic physical conditions (e.g., diabetes, heart failure, etc.) and co-existing behavioral or substance abuse conditions. We also anticipate that our target population will include the top 5% of patients who account for over 50% of health care expenditures at RUHS.

- ***Vision for Care Delivery***: The Complex Care Management Project will serve as a critical foundation for the transformation of our delivery system from a

fragmented and reactive model of care into an integrated, proactive, and whole-person centered model of care. We envision our high-risk populations will experience a significantly higher quality of care as a result of having their most important needs met in a proactive, integrative, and collaborative manner. We believe that if we can learn how to best assist and support our highest risk populations, we will be able to generalize this set of experience, skills, and approach to our patient population at large.

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

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

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

☒ 2.6 – Chronic Non-Malignant Pain Management

RUHS has selected the Chronic Non-Malignant Pain (CNMP) Management Project to expand and standardize patient access to primary care pain management resources. The increasing numbers of patients diagnosed with conditions related to CNMP can be at risk for continued pain due to care gaps that include: incomplete evaluation, suboptimal access to treatment, inadequate depression screening, and inadequate recognition of potential substance abuse disorders.

Proposed implementation includes:

- ***Enterprise-Wide Strategy****:* The development of provider and clinic staff education curriculum will serve as the foundation for the project. It will include best practices for workflow, coding, and utilization of standardized tools (pain evaluation, care agreement, urine drug screening, depression screening, substance abuse disorder screening). Utilization of the EHR CNMP-specific templates will serve as a tool to simplify documentation, enhance evaluation, required task notification, and

recommend multi-modal therapies. Clinics utilizing a paper chart-based system will utilize a CNMP-specific checklist and progress note template adapted from the EHR until the clinics have transitioned to the new EHR.

- ***Nationally recognized methodology**:* Centers for Disease Control and Prevention (CDC) guidelines and best practices adapted from evidence-based guidelines serve as the structure for the assessment and management strategies.

- ***Provider Feedback**:* Maintenance of provider care team engagement will be reinforced through quarterly report cards generated from EHR data. Actionable data will provide feedback on how provider care team chronic pain management compares to peers and benchmarks. Local clinic leadership and the quality improvement team will identify provider care teams requiring assistance with standardized education to improve proficiency.

- ***Coding**:* ICD-9/ICD-10 codes will be utilized for data collection to identify patients with CNMP, develop a registry for pain assessments, care agreements, medication refills, and urine toxicology. Coding will be specific to anatomy and condition, but will also include required chronic pain coding to assist in identification of CNMP cases.

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

- ***Target Population**:* Targeted patients will include those:
  - with conditions resulting in CNMP
  - with undiagnosed CNMP
  - on long-term controlled medications, patients at risk for substance abuse disorders, patients with mental health conditions

- ***Vision for Care and Delivery**:* The CNMP Management Project is an opportunity to expand evidence-based best practices to all RUHS primary care clinics. System-wide utilization will standardize provider baseline approach, increase identification of CNMP-related conditions, enhance patient evaluation, increase access to CNMP management resources, increase behavioral health evaluation, and increase identification and treatment of substance abuse disorders. Data extracted through documentation can be utilized to track patient outcomes, reduce care gaps, identify areas for improvement, and reinforce provider care team engagement.

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

Check, if applicable	Description of Core Components
Applicable	**2.6.1** Develop an enterprise-wide chronic non-malignant pain management strategy.
Not Applicable	**2.6.2** Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**2.6.3** Implement or adapt a state or nationally recognized methodology for the assessment and management of chronic pain.
Not Applicable	**2.6.4** Implement protocols for primary care management of patients with chronic pain including: • A standard standardized Pain Care Agreement. • Standard work and policies to support safe prescribing practices. • Comprehensive pain history including psycho/social evaluation, functional evaluations, care plan, pain medication risk/benefit informed consents, ongoing monitoring of plan/outcomes (e.g., use of standardized monitoring template for follow-up visits for CNP), aberrant behavior screening and management protocols. • Guidelines regarding maximum acceptable dosing.
Not Applicable	**2.6.5** Provide culturally, linguistically and literacy level-appropriate patient education on the pathology of chronic pain, rationale for rehabilitation and expected goals of treatment.
Not Applicable	**2.6.6** Coordinate a chronic pain care team that minimally consists of a physician champion and medical support staff. Suggestions for care clinicians from other disciplines include occupational and physical therapy, behavioral health, pharmacy, substance use disorder specialists, neurology, occupational medicine, anesthesiology/pain management, home care, social work, and physical medicine and rehabilitation.
Not Applicable	**2.6.7** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, and team based population/panel management and care coordination.
Applicable	**2.6.8** Determine population ICD-9/ICD-10 codes for data collection that is unique to patients with chronic pain on opioids and develop a registry for pain assessments, care agreements, medication refill standing orders and urine toxicology screening.
Applicable	**2.6.9** Utilize provider activity report card to provide feedback to providers on how their chronic pain management practice compares to peers and benchmarks.
Not Applicable	**2.6.10** Establish a policy for monitoring and maintaining opioid agreements for prescription refills with other clinics, pharmacies, dentists

Check, if applicable	Description of Core Components
	and specialists.
Not Applicable	**2.6.11** Develop a process for scheduling pain focused follow-up patient visits to ensure that patients receive refills in a timely manner while also receiving recommended monitoring for signs of diversion or misuse.
Applicable	**2.6.12** Develop staff and clinician training regarding the organization's process for managing patients with chronic non-malignant pain.
Not Applicable	**2.6.13** Train providers to identify signs of prescription opioid use disorders and provide treatment options for patients diagnosed with opioid use disorders, including suboxone treatment, referral to methadone maintenance, referral to inpatient and outpatient substance use disorder treatment facilities, and referral to needle exchanges.
Not Applicable	**2.6.14** Develop and implement protocols for prescribing naloxone to patients receiving opioids for chronic pain.
Not Applicable	**2.6.15** Identify standardized multidimensional pain assessment, functional assessment, psychological assessment, and opioid assessment tools that meet the needs of the care clinicians and are appropriate for the patient populations.
Not Applicable	**2.6.16** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. Timely, relevant and actionable data is used to support patient.

Please complete the summary chart:

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

Section 4.3 – Domain 3: Resource Utilization Efficiency

☒ 3.3 – Resource Stewardship: Therapies Involving High Cost Pharmaceuticals

RUHS selected this project because, in most hospitals, the cost of pharmaceuticals significantly drives expenses. Often the procurement, delivery, and use of pharmaceuticals has been viewed as a cost that rises, subject to inflation. In the current health care environment safety net providers need to continue finding ways to be prudent stewards of financial and pharmaceutical resources.

We have an opportunity to challenge high-cost pharmaceutical utilization through optimal procurement and evidence-based use and delivery of such pharmaceuticals. A review of procurement strategies has begun, but would benefit from multidisciplinary partnership in designing appropriate use programs for therapies. Such focus on this resource and stewardship could become a standard for the health care industry in the way care is funded, coordinated, and approached.

Our planned implementation approach includes:

- ***Implement a Multidisciplinary Stewardship Team****:* This team will be established to design new strategies for optimal use and targeting of pharmaceuticals. It will also review any ongoing initiatives, and share findings.

- ***Develop data analytics process****:* A strong data analytics program will be established because it is essential to driving the successful achievement of many of this project's core components.

- ***Develop Organization-Wide Provider-Level Dashboards****:* They create transparency and insight to variances in practice and prescribing. Dashboards should improve standardization of prescribing and possibly reflect use of protocols and order sets for high-cost, high-risk therapies. They will also assist in the design of training methods and sharing among practitioners.

- ***Maximize Access to 340b Pricing****:* The regular review and monitoring of

340b utilization and program integrity are essential. Development of monitoring tools and sharing of best practices improves compliance. Our goal is to identify new techniques to demonstrate the value of the 340b program, and increase the ability to re-invest in services that benefit the community.

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

- ***Target Population.*** Adult patients will be included in our primary target populations. Proposed selection criteria include: those being treated with high-risk/high-cost medications, or with medications known to have complex regimens, or when high levels of patient adherence to therapy are critical to treatment success. We will identify the initial target populations by reviewing utilization data for high- cost, efficacy medications. As data are collected and evaluated, there may be an expansion of the target population.

- ***Vision for Care Delivery****:* Establishment of a multidisciplinary stewardship team will promote organizational awareness and insight to align resource stewardship with system-wide goals. The multidisciplinary team will include target physician groups and nursing services, and will ultimately share discussion at the Pharmacy and Therapeutics Committee. The stewardship team will be active based on review of other core components such as #3 review of the data analytics process for sound methodology, #4 develop processes for evaluation of impact, and #7 develop formulary alignment as needed.

  Robust dashboards will improve the standard of care across a diverse organization and should drive best practices. Provider awareness enhances the greater health of the community. In order to take action on dashboard results, and to combine it with effective messaging for impact, it will be essential to address parts of other core components: #5 processes to impact prescribing and #6 improve the process for proper billing of medications. Optimization of 340b program utilization reduces unnecessary spending, while allowing mobilization of resources to expand care for the community.

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

Check, if applicable	Description of Core Components

Check, if applicable	Description of Core Components
Not Applicable	**3.3.1** Implement or expand a high-cost pharmaceuticals management program.
Applicable	**3.3.2** Implement a multidisciplinary pharmaceuticals stewardship team.
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).
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.
Not 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.
Not 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.

Check, if applicable	Description of Core Components
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.
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.
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 $ 66,759,000
- DY 12 $ 66,759,000
- DY 13 $ 66,759,000
- DY 14 $ 60,083,100
- DY 15 $ 51,070,635

Total 5-year prime plan incentive amount: $ 311,430,735

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 - **Not applicable to RUHS**

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

Appendix

Table 1. Map of RUHS – Medical Center and RUHS – Care Clinic Sites

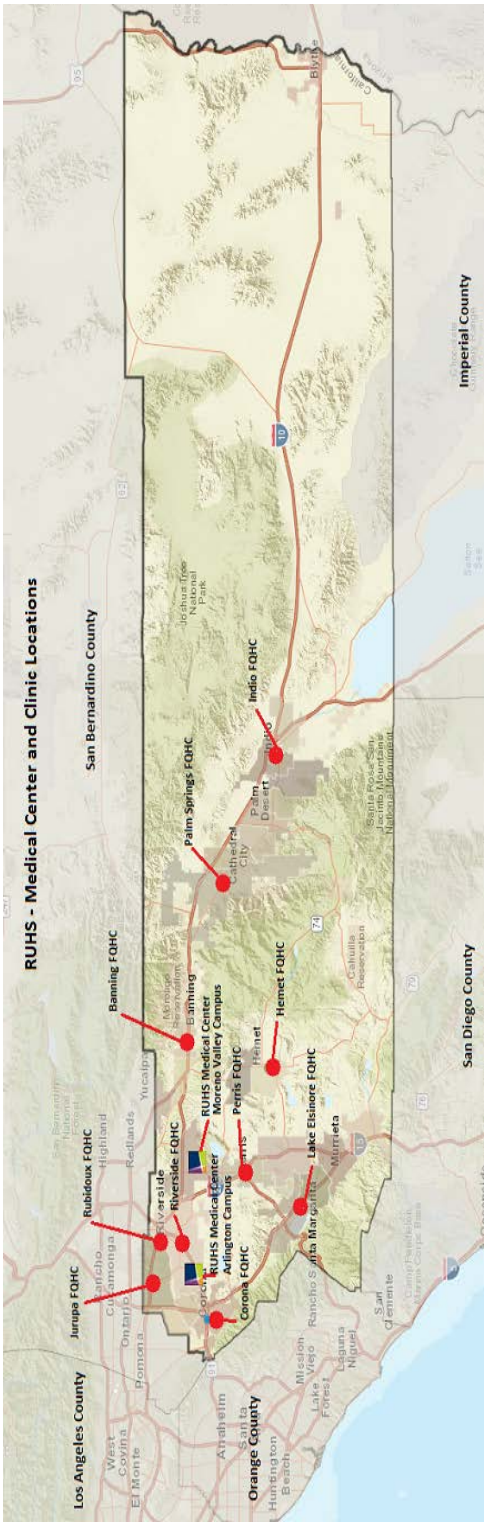
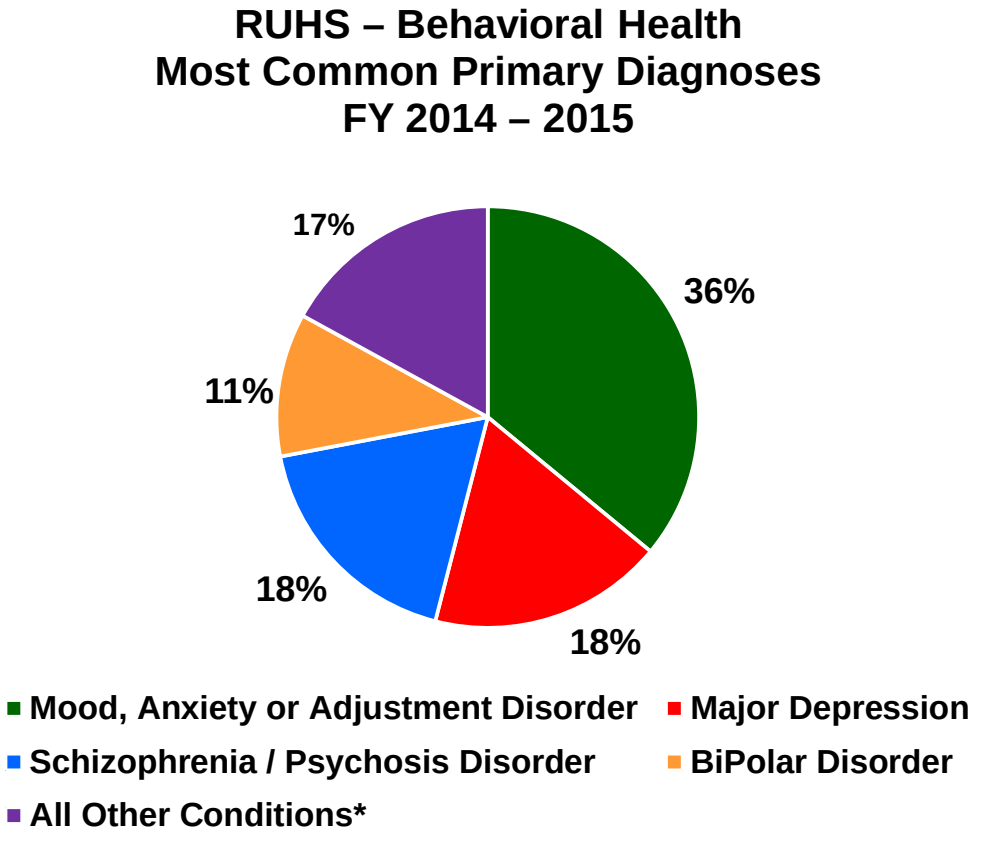


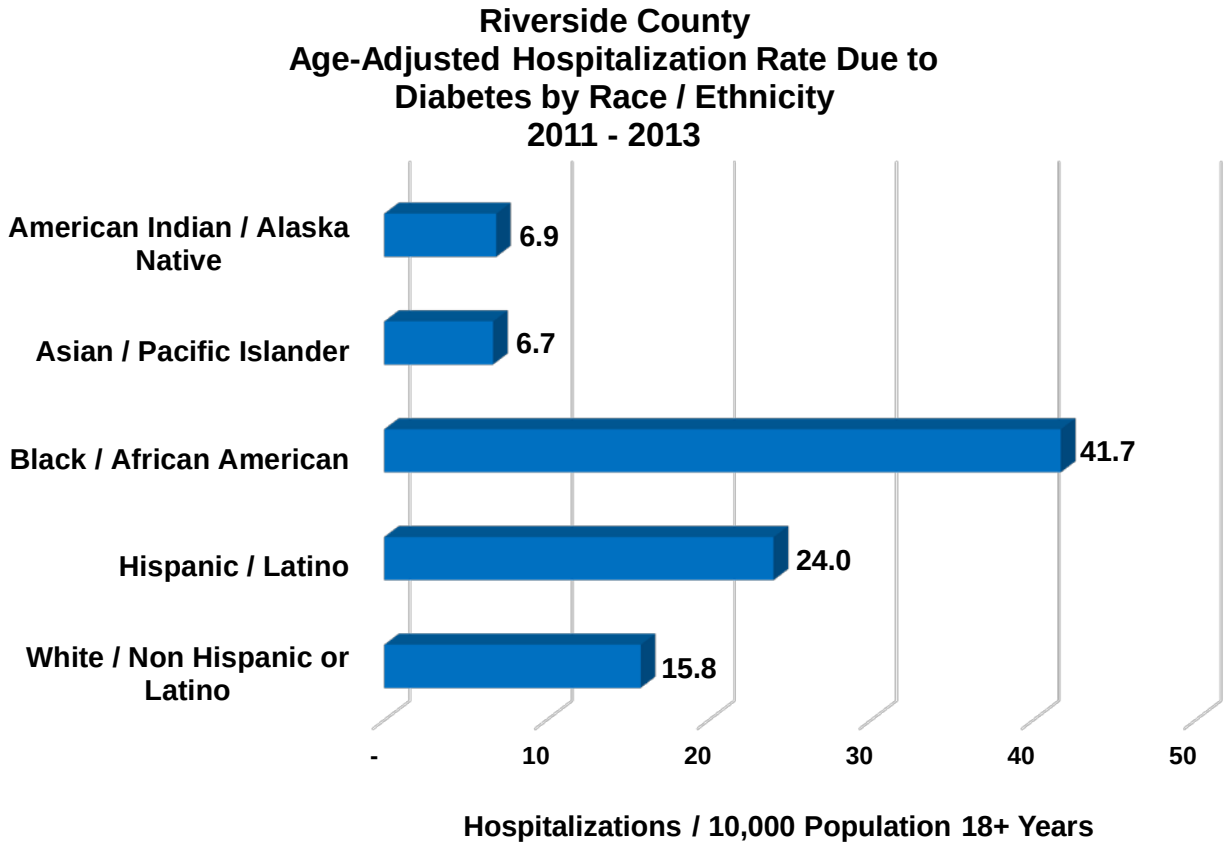
Table 2



*** Includes AD/D, Drug/Alcohol, Other**

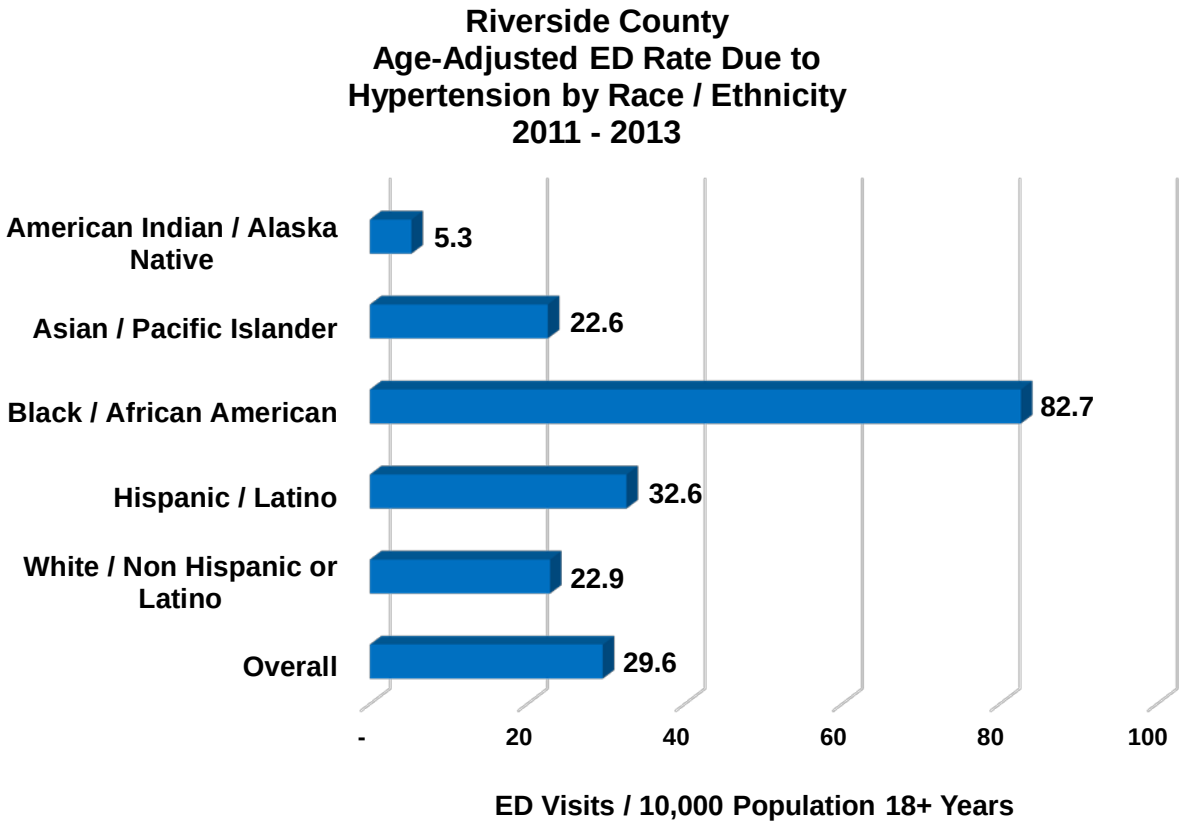
Source: RUHS – Behavioral Health

Table 3



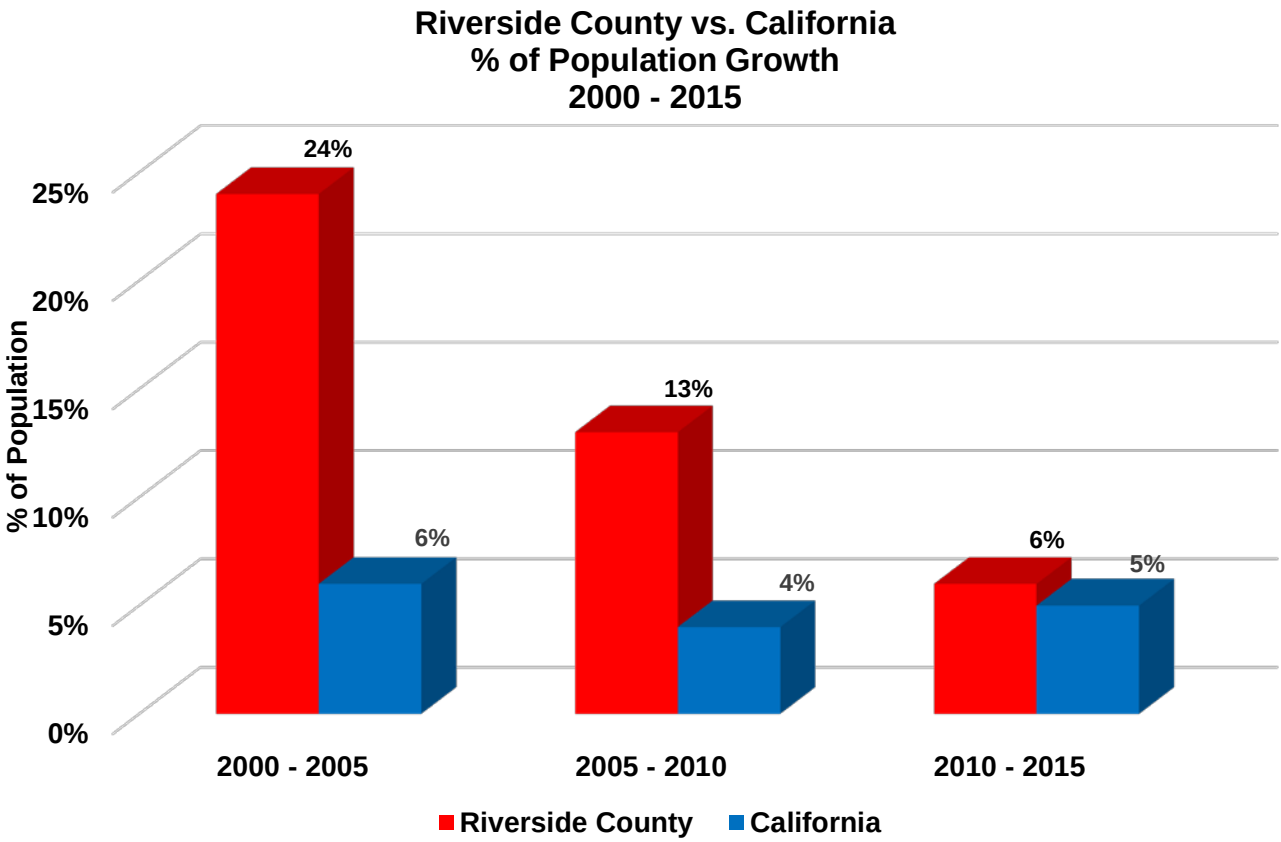
Source: California Office of Statewide Health Planning and Development

Table 4



Source: California Office of Statewide Health Planning and Development

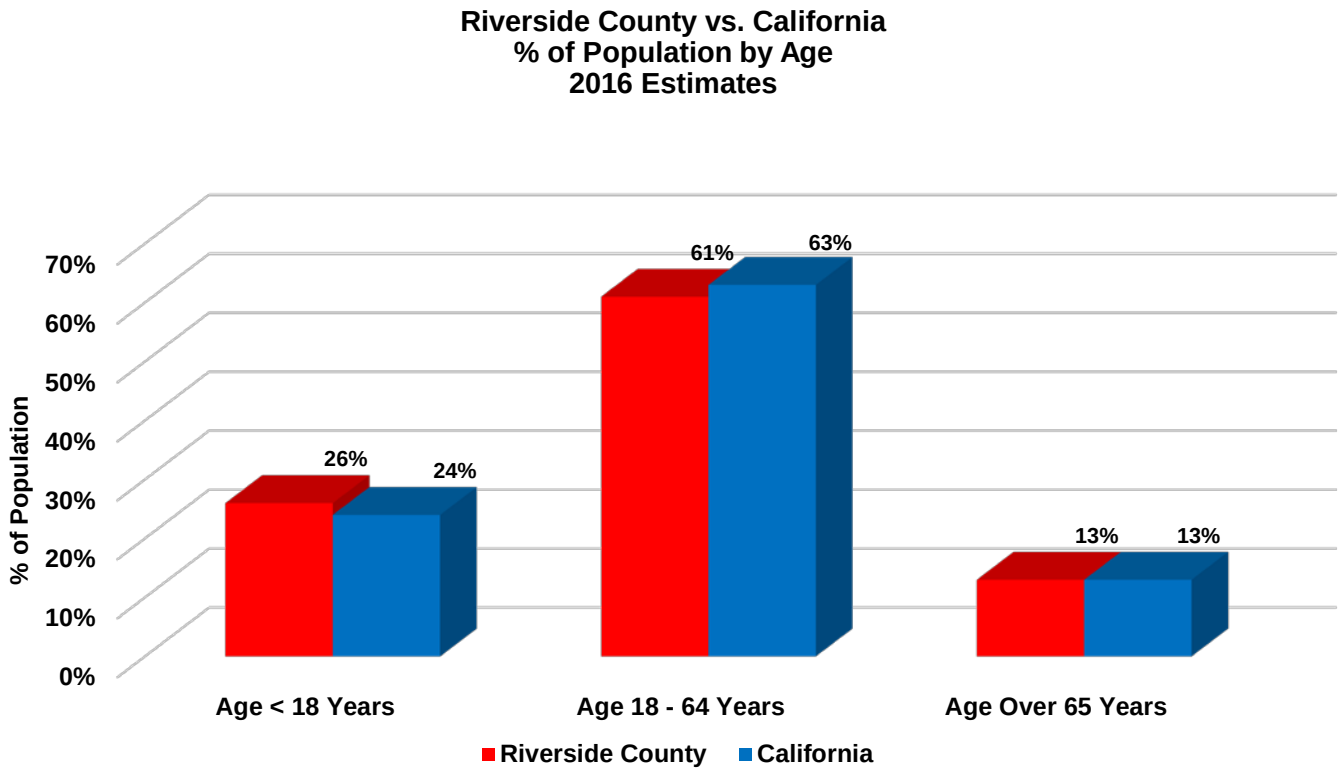
Table 5



Source: California Department of Finance

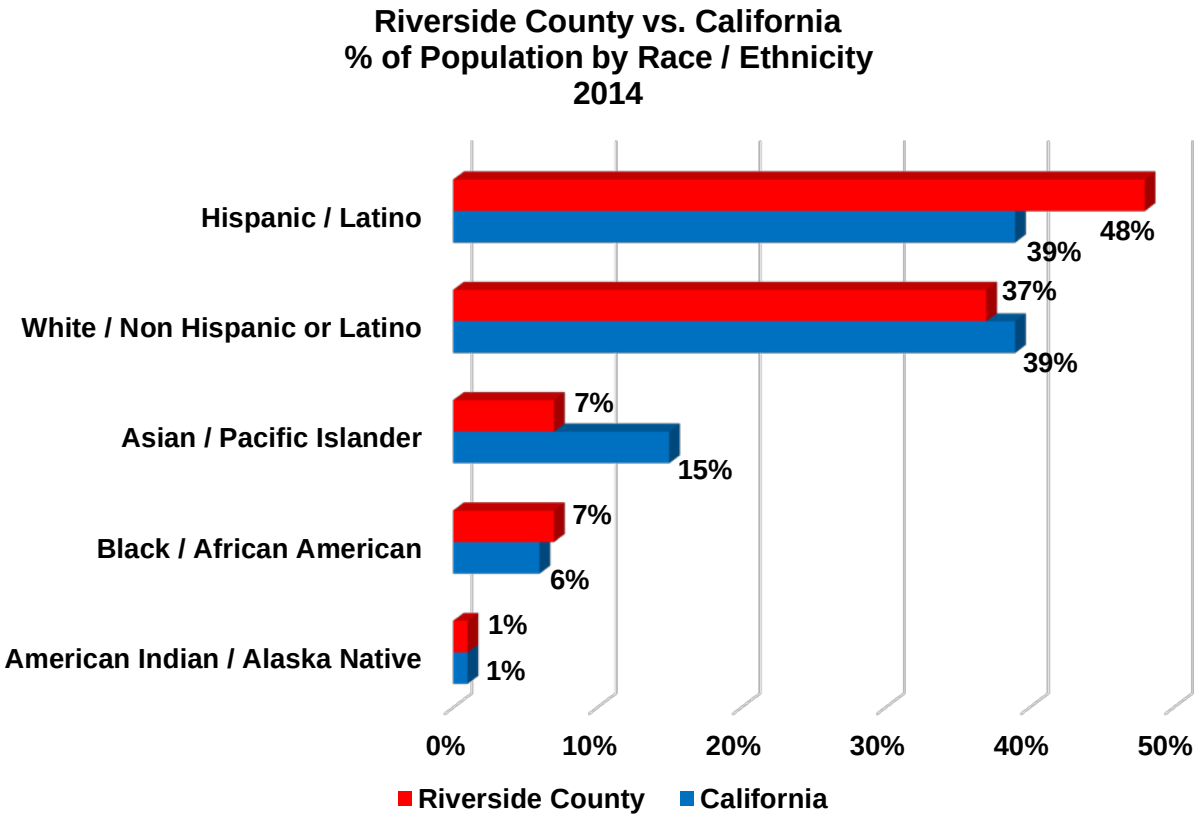
	2000	2005	2010	2015
Riverside County Population	1,557,271	1,934,723	2,195,306	2,331,040
California Population	34,000,835	35,985,582	37,339,485	39,071,323

Table 6



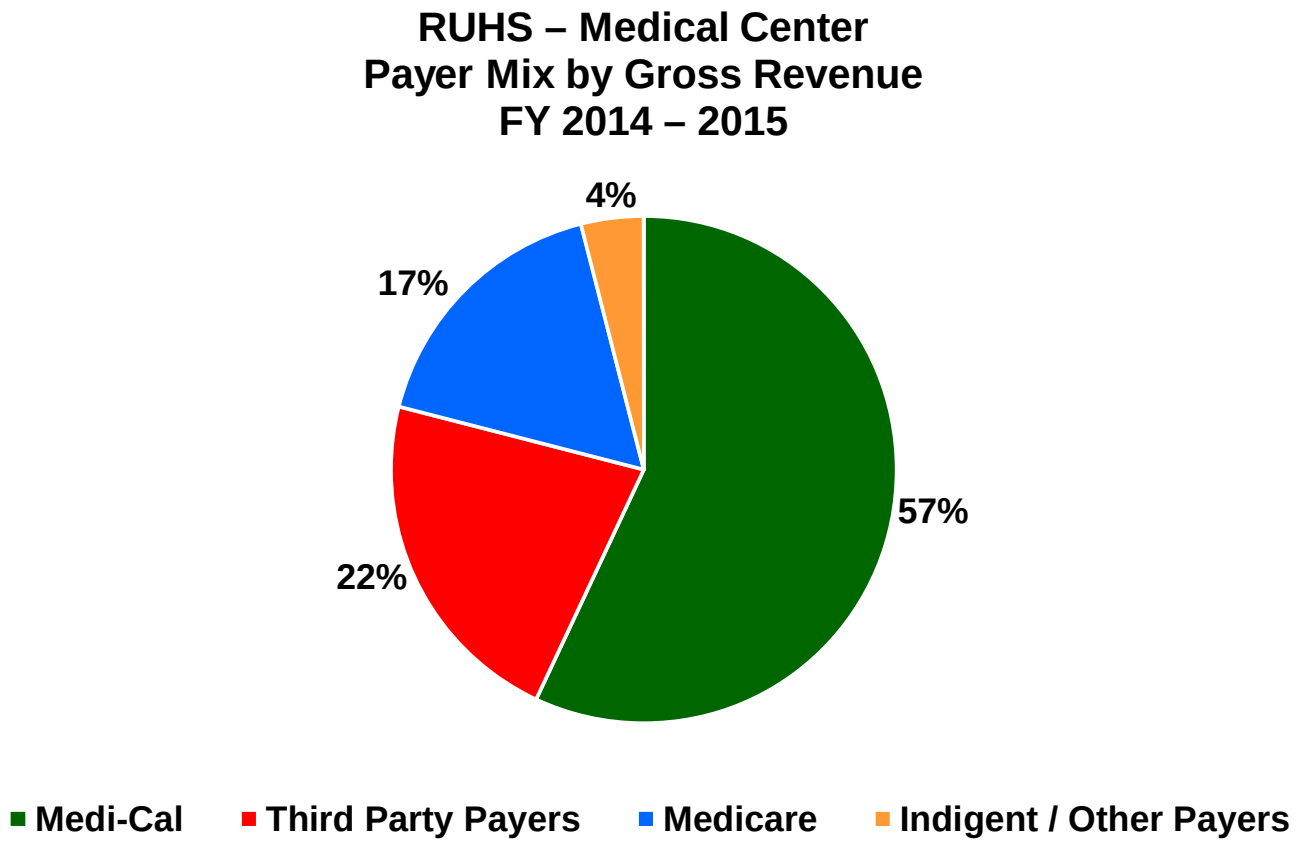
Source: Claritas; Obtained from County of Riverside, SHAPE Demographics Dashboard, 2016

Table 7



Source: U.S. Census, QuickFacts Report, 2014

Table 8



Source: California Office of Statewide Health Planning and Development

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[15] U.S. Census. *Quick Facts Report, Riverside County and California, 2014*. www.census.gov/quickfacts/table/PST045215/00,06,065)

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