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**

UC Irvine Medical Center

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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	UC Irvine Medical Center
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.

UC Irvine Medical Center (UCIMC), located in Orange, is centrally located within the County of Orange. UCIMC has, through an analysis of secondary and primary data, identified local community health needs to include:

Mental Health. 6.3% of adults experienced serious psychological distress in the past year. 14.9% of adults saw a health care provider for emotional, mental health, alcohol or drug issues, however; 55.3% of those who sought or needed help did not receive treatment. Healthy People 2020 objective is for 64.6% of adults with a mental disorder to receive treatment. 11.1% of adults took prescription medicine for emotional/mental health issues in the past year.

Access to Care. Insurance coverage is a key component in accessing health care. In Orange County, 82.7% of the total civilian non-institutionalized population is insured. The 2015 Orange County Community Indicators found, between October 1, 2013 and March 31, 2014, 131,804 residents enrolled in Covered California. As of December 2015, 780,000 residents were enrolled in the CalOptima MCP. 11.25% of the population remained uninsured. 15.6% of the population report no regular source of care, or that they access care through an Emergency Department.

Chronic Diseases. Among the population, 17.4% report being in fair/poor health, slightly higher than the California rate of 17%. Chronic diseases include:

Diabetes – 7.1% of adult population diagnosed; 12.2% report not being confident to manage their diabetes.

Heart Disease – 6.3% of adults diagnosed. 13.7% report not confident to control their condition.

Cancer – The five-year age-adjusted cancer incidence rate is 418.6 per 100,000 persons. Cancer rates of male genital, digestive system, female genital, and urinary system were all significantly lower than the state average. Cancers of breast, skin, and endocrine system/thyroid had modest but significantly higher rates. Other differences were non-significant.

Asthma – 14.6% of the population has been diagnosed with asthma. 95.8% had symptoms in the past year and 53.9% take daily medication to control their asthma. Among youth, 10.9% have been diagnosed with asthma, and 35.9% have visited the Emergency Department as a result of their asthma.

The community served by UCIMC is ethnically diverse and is comprised of many cultural backgrounds. UCIMC has a primary emphasis on providing health care in a culturally appropriate manner to our community's diverse population.

We hope that participating in PRIME will provide ways we can improve the accessibility and quality of health services for the populations referenced above as well as other portions of the Orange County population.

2.2 Population Served Description. *[No more than 250 words]*

Summarize the demographic make-up of the population included in your hospital's service area, including information about per capita income, age, race, ethnicity, primary language, etc.

UC Irvine Medical Center primarily serves the diverse population of Orange County. Orange County's population is 3,160,437 Californians. There are 34 cities in the county and also a number of unincorporated areas. The largest cities are Santa Ana and Anaheim.

Race/Ethnicity and Language.

White	43.5%
Hispanic or Latino	33.8%
Asian	18.2%
Other or Multiple	2.4%
Black or African American	1.5%
Native Hawaiian/Pacific Islander	0.3%

American Indian/Alaska Native	0.2%

In Orange County, 54.5% of residents speak English only. Spanish is spoken in 26.5% of homes. Nearly 14% speak an Asian or Pacific Island language. Other languages are spoken in 4.2% of households.

Income.

The median household income in Orange County is $75,422. This is higher than the California median of $61,094. Among Orange County residents, 12.4% are at or below 100% of the Federal Poverty Level (FPL) and 29.5% are at or below 200% of FPL

Age.

Orange County's age distribution is similar to California, but it is a slightly older population with a median age of 36.4 compared to 35.2 for California. Orange County's age distribution is as follows:

Age 0 - 4	6.3%
Age 5 - 17	17.7%
Age 18 – 24	10.2%
Age 25 – 44	28.1%
Age 45 – 64	25.7%
Age 65 +	12.0%

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.

UCIMC is an integral component of UC Irvine Health. UCIMC is a 411 bed general acute care hospital and Orange County's only academic medical center providing tertiary and quaternary care, primary and specialty medical clinics, behavioral health and rehabilitation. It is the primary teaching location for the UC Irvine School of Medicine. UCIMC has been rated among the nation's best hospitals by *U.S. News & World Report* for 15 consecutive years and is ranked No. 1 in Orange County. It is home to county's only adult Level I and pediatric Level II trauma center. Our Chao Family Comprehensive Cancer Center is one of 45 in the nation so designated by the National Cancer Institute. More than 100 faculty physicians are listed as Best Doctors in America by Best Doctor, Inc.

UCIMC is also home to the UC Irvine Family Health Center, a Federally Qualified Health Center, with locations in Santa Ana and Anaheim.

Licensed bed categories include: 60 Intensive Care, 45 Intensive Care Newborn Nursery, 22 Perinatal, 14 Rehabilitation, 8 Burn, 214 unspecified Acute Care, and 48 Acute Psychiatric beds. In 2015, the payer mix was 31.05% Medicare, 42.34 % Medi-Cal, 24.90 % Commercially Insured, and 1.71% other indigent care. In Fiscal Year 2015, UCIMC provided 20,234 patient admissions, 666,183 ambulatory visits. Our occupancy rate in 2015 was 77.19 % (licensed beds), 77.20% (available beds).

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.

Data collection: Data collection for reporting is a critically important function that is integrated into the daily responsibilities of numerous staff throughout UCIMC. Front-line patient care workers collaborate with staff in our Quality, Information Technology and other departments to ensure that data is entered into the Electronic Medical Record (EMR) and other systems in a timely and accurate manner. Whenever possible, data entry systems are configured with structured data fields to facilitate specific and reliable data retrieval.

Data retrieval: The bulk of electronic data retrieval and reports creation is performed by the Clinical Informatics development team of the Information Technology department, utilizing an enterprise-wide data warehouse that includes data from multiple systems across the organization. Subject matter experts in clinical and administrative roles work directly with data query developers to ensure that measure content is appropriately captured.

Governance and monitoring: Data governance and monitoring at UCIMC are provided by the Quality and Safety Oversight Committee (QSOC), at the direction of the Chief Medical Officer. Data is disseminated by QSOC and its subcommittees to stakeholders throughout the organization, including department chiefs and providers.

Certain PRIME measures (either innovative measures or those including data that will need additional system configuration for electronic reporting) will initially require manual data abstraction from patient medical records. Members of the Quality department and/or other departments as appropriate will be assigned to complete this work until electronic data retrieval is possible.

Another potential barrier to PRIME reporting for UCIMC is the anticipated transition to a new EMR system in DY12 and DY13. Work is currently in progress to address this issue by creating structured data mapping of codes and fields in order to allow reporting across time for specific data elements.

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.*

   Providing our patients with high quality, culturally competent, evidence-based, patient-centered health care is a major objective for UCIMC. We embrace the opportunities that PRIME will offer to support further transition toward population health based care, APMs and value-based payments.

   Transformation of the UCIMC health system will be guided by our aspirations to:

   - Provide excellent care and an exceptional patient experience
   - Educate the next generation of healthcare leaders through innovative learning
   - Achieve distinction in basic, translational, clinical and outcomes research
   - Become a leader in population health management
   - Be the region's top destination for complex care

2. *List specific aims** for your work in PRIME that relate to achieving the stated goals;*

Note:
*** Specific aims (generally 2-5) relate to the goals but provide more detail on how the goals will be achieved.*

Specific aims of the UCIMC PRIME program are to:

- Redesign ambulatory behavioral health, primary care and specialty care services delivery for improved care management across the organization and continuum of care via improved screening, access and referral processes.
- Create and implement specific care strategies for perinatal, chronic non-malignant pain and complex care patient groups to improve patient experience and clinical outcomes, and to reduce over-utilization of services.
- Expand standard procedures, protocols and guidelines for antibiotic stewardship to promote consistent and reliable care delivery, reduce overuse and improve clinical outcomes.

Where appropriate, we plan to collaborate with CalOptima to share learnings based on PRIME Project accomplishments and assist in providing educational opportunities for other providers.

Efforts planned to reduce health disparities of underserved populations include the following:

- Collaboration across the UC Irvine health sciences to develop models that address the underserved.
- Leverage core competencies developed with our Federally Qualified Health Center (UC Irvine Family Health Center, with locations in Santa Ana and Anaheim) to enhance delivery models.
- Partner with other health systems and community resources to address health disparities within our community.

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;*

UCIMC plans to redesign ambulatory care for improved care management via selected core components of Projects 1.1 (Integration of Behavioral Health and Primary Care), 1.2 (Ambulatory Care Redesign: Primary Care), 1.3 (Ambulatory Care Redesign: Specialty Care), 1.4 (Patient Safety in the Ambulatory Setting) and 2.2 (Care Transitions: Integration of Post-Acute Care). Strategies for Projects 2.1 (Improvements in Perinatal Care), 2.3 (Complex Care

Management for High-Risk Medical Populations), 2.6 (Chronic Non-Malignant Pain Management) will be applied to improve patient experience and clinical outcomes in our high-risk, high-utilization patient groups. Finally, we will use Project 3.1 (Antibiotic Stewardship) to drive clinical excellence related to antibiotic use.

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);*

   Each of the nine projects that UCIMC chose complements the work efforts of one or more of the other projects. Appropriate chronic non-malignant pain management and provision of behavioral health care are closely linked. Improved transitions of care and care management will require improved processes in primary and specialty care services. Integration of post-acute care is a requirement for comprehensive antibiotic stewardship, as many patients continue antibiotic treatment after discharge and must be closely followed to avoid readmission. Aggressive management strategies for perinatal care and heart disease prevention must be integrated into primary and specialty care services to have maximum impact and benefit. Project teams will continue to look for and leverage project synergies throughout PRIME.

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.*

   UC Irvine Health aims to provide excellent clinical care and patient experience to its community and to become a leader in population health management. Over the next five years, UC Irvine Health will build the infrastructure to reduce health disparities of underserved populations by enhancing delivery models at our FQHCs, by collaborating across the health sciences to develop models that address underserved areas clinically and geographically and by partnering with other health systems and community resources to address health disparities within the community.

   At the conclusion of PRIME, we anticipate that our patients will be empowered and engaged in the well-coordinated, seamless care they receive at UCIMC. Improvements in processes and infrastructure will allow the patient care team to holistically treat each patient in a way that minimizes disparities and promotes patient experience and clinical outcome excellence.

   Relationships with community-based resources and managed care partners will be expanded with shared learning that benefits the involved entities and the patients they serve, and UCIMC will be well-positioned for transition to APM's with strong quality and utilization performance to promote financial sustainability.

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.

Mental Health. UCIMC will be working to increase access to mental health resources and services. There are current barriers to care that exist in the Orange County system. The objectives identified in PRIME Project 1.1 are most consistent with our goals to work toward greater integration of mental health and physical health services, including within the primary care environment. We also intend to collaborate with our UC Irvine Family Health Center, CalOptima, and the County of Orange Health Care Agency to accomplish these goals.

Access to Care. UCIMC's goal is to increase access to care, especially for the medically underserved, and improve community health through preventive practices. We look forward to what we will learn and accomplish through pursuit of PRIME 1.2 that will increase coordination of effective and efficient primary care, and the benefits of timely preventive care. Collaborators will include CalOptima and the County of Orange Health Care Agency as well as our UC Irvine Family Health Center.

Chronic Diseases. UCIMC is striving to reduce the impact of chronic disease in our community through an increased emphasis on prevention, appropriate treatment, and meaningful education. PRIME Projects 1.3 (ambulatory care redesign: specialty care) and 2.3 (complex case management) will aid as a catalyst in pursuing these aims. We also intend to collaborate with the American Cancer Society, the American Heart Association, CalOptima, and our UC Irvine Family Health Center.

Efforts to improve care for the population and individual patients will also focus on appropriate utilization and improving the 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).

UCIMC, as part of the University of California Health system, has a strong commitment to our patients and the communities we serve. As a University of California medical center, we are guided by the policies and community commitment of the Regents of the University of California, and the UC Irvine Vice Chancellor of Health Affairs. UCIMC leadership is most aware and knowledgeable regarding the need to find ways to reduce utilization without compromising patient care, and striving to meet the health needs of our community.

UCIMC leadership oversight will be provided by the Executive Leadership Team which is chaired by the Vice Chancellor of Health Affairs. UCIMC has also established the PRIME Steering Committee chaired by the Chief Medical Officer and includes representation from each PRIME Project. Project operational oversight will be provided through the PRIME Steering Committee. The PRIME Steering Committee will keep the Executive Leadership Team apprised of progress on a regular basis, assuring an organizational ongoing commitment to and alignment with PRIME at the highest level. The PRIME Steering Committee will be responsible to recommend any necessary institutional investments, the monitoring of progress of projects in the achievement of their performance standards and goals. The PRIME Steering Committee will meet at least monthly – and individual meetings with focus on specific projects will be held as needed.

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.

Patient and other stakeholder engagement will be valuable to successful PRIME Project performance. UCIMC has established a committee which is focused on improving the patient experience, the Exceptional Patient Experience Committee. Patient representation is included on this committee. Also, the UC Irvine Family Health Center, as a Federally Qualified Health Center, is governed by a Board of Directors which also has patient members. This Board will be regularly updated on relevant PRIME project progress and input will be sought.

A regular collaborative liaison with the CalOptima MCP will be maintained for exchange of ideas and input over the term of the PRIME Projects.

UC Irvine Medical Center is a significant participant in the Orange County Health Improvement Partnership (OCHIP). The OCHIP is convened by the Orange County Health Care Agency Public Health Division and is a forum for government, health care provider and community leaders to come together and work collaboratively toward a vision that "Orange County is a community where everyone feels safe and has opportunities and resources to be healthy and enjoy optimal quality of life." Addressing discovered health disparities is also part of the OCHIP agenda.

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.

UCIMC embraces the goal of meeting the needs of the clearly diverse population we serve. We work on ensuring that our faculty and staff reflect and respect the diversity of our patient population. Be it from the need to provide care in their language of choice, to making every effort to provide patient care in a culturally competent manner, all these factors contribute to the provision of high quality care in an environment that improves the patient experience by respecting our differences.

We continue to assure that patient educational materials are translated into our identified threshold languages and we provide real-time access to interpreter services in addition to providers with language capabilities. Many of our faculty and staff are bi-lingual. We continue to assess new ways we can be more responsive to the multi-faceted needs of our diverse patient population and community. UCIMC practices the values of a) honoring patient's beliefs, traditions and customs; b) recognizing individual differences within a culture; c) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and d) through cultural diversity training, fostering in staff attitudes and interpersonal communication styles that respect patient's cultural backgrounds.

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.

UCIMC has a performance improvement department dedicated to process Improvement /Lean Six Sigma (LSS), Change Management, and Project Management. To date, 731 staff have been trained to understand and utilize Lean Six Sigma Define, Measure, Analyze, Improve, Control (DMAIC) tools and methodologies. We average over 50 active improvement projects that are mentored through the Control Phase. Projects focus on quality/outcomes, efficiency, and the patient experience. Each project presents to an executive team to demonstrate sustainability. Leaders attend training on change management. The Performance Improvement Team utilizes the Prosci ADKAR® methodology and involves staff and leaders in change management in support of active change implementations.

UCIMC will support and sustain PRIME Improvements by:

- Ensuring senior level sponsorship for PRIME projects
- Using LSS methodologies to engage staff and stakeholders in designing improvement strategies
- Use of data driven analysis and decision making, and reporting baseline and sustained improvement metrics
- Providing change management support to each project

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)

UCIMC will utilize this project to address the significant need to provide behavioral health services to our patients. Improving identification and management of behavioral health needs will improve the overall health outcomes of patients in primary care, especially those with chronic disease. There are many components necessary for behavioral health care in primary care, and there is much opportunity for developing a coordinated approach. We will initiate this project with our Patient-Centered Medical Home site, and then with the health system as a whole.

- UCIMC will implement the Collaborative Care model (as described by SAMHSA and the University of Washington), a nationally-recognized behavior model for integrating behavioral health into our medical model. We plan to begin implementation of this model for our high risk patients in selected sites (i.e. our Senior Health Center and FQHC clinics) and then to expand to a broader group of patients over subsequent years. Expected implementation activities include: initiation of depression screening, development and improvement of referral processes for psychiatric services, and expansion of clinic services to provide on-site psychiatric care sessions.
- We will ensure coordination of care and access to chronic disease management support for patients needing behavioral health interventions, with consideration for the cultural and linguistic diversity of our patient population.
- An interdisciplinary treatment plan will be developed to address behavioral health issues, medical issues and substance abuse issues, as well as social, cultural and educational needs of patients. Treatment options will include traditional and non-traditional interventions, wellness, and symptom management options.
- Care will be provided using a team based model that optimizes staff abilities and credentials. Training will be provided for the team-based intervention, with an emphasis on quality and safety.
- Outcomes will be evaluated and monitored for a continuous cycle of improvement.

This project will be implemented utilizing the following guideline:

DY11- Concept Development and Planning

DY12- Pilot with a specific population

DY13- Expand Pilot to a broader population

DY14 &DY15- Integrate with majority of primary care sites

Target Population: We anticipate that our target population will eventually include all adult and pediatric populations, and we intend to begin with a sub-population of geriatrics patients within our Patient-Centered Medical Home site. This group is at particular risk of behavioral health issues due to comorbidities such as dementia.

Vision for delivery of care: Our vision is to establish a coordinated, comprehensive primary care delivery model which aims to improve both physical and behavioral health outcomes, within an efficient, patient centered, culturally and linguistically adept model. In this new primary care delivery model the traditional resources would be expanded to include support for identifying and treating mental health and substance abuse disorders as an entity of primary care delivery. Primary care teams would be trained and designed to provide care within a multidisciplinary team that utilized quality care metrics to measure benchmarks for care and drive performance improvements.

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

Check, if applicable	Description of Core Components
Applicable	**1.1.1** Implement a behavioral health integration assessment tool (baseline and annual progress measurement)
Applicable	**1.1.2** Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration, the Collaborative Care Model, or other Integrated Behavioral Health (IBH) resources from SAMHSA)
Not Applicable	**1.1.3** Integrate appropriate screening tools and decision support into the emergency department (ED) to ensure timely recognition of patients with mental health and substance use disorder problems. Enhanced access to primary care and/or to behavioral health specialists will be integrated into discharge planning for these patents. Use of 24-7 care navigators (e.g., Community Physician Liaison Program) may be used to support linkages to primary care providers (PCPs), mental health (MH) and substance use disorder (SUD) specialists and behavioral health and other community services through the discharge process.
Applicable	**1.1.4** Integrate physical and behavioral health, either through implementation of a new program or an expansion of an existing program, from pilot sites to hospital and health system primary care sites or from single populations to multiple populations (e.g., obesity, diabetes, maternal, infant, and child care, end-of-life care, chronic pain management).
Not Applicable	**1.1.5** Patient-Centered Medical Home (PCMH) and behavioral health providers will: • Collaborate on evidence based standards of care including medication management and care engagement processes. • Implement case conferences/consults on patients with complex needs.
Applicable	**1.1.6** Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families.
Not 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.

Check, if applicable	Description of Core Components
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.
Applicable	**1.1.10** Ensure the development of a single treatment plan that includes the patient's behavioral health issues, medical issues, substance abuse, social and cultural and linguistic needs. This includes incorporating traditional medical interventions, as well as non-traditional interventions such as gym memberships, nutrition monitoring, healthy lifestyle coaching, or access to culturally and linguistically appropriate peer-led wellness and symptom management groups.
Not Applicable	**1.1.11** Ensure a culturally and linguistically appropriate treatment plan by assigning peer providers or other frontline worker to the care team to assist with care navigation, treatment plan development and adherence.
Not Applicable	**1.1.12** Ensure that the treatment plan: • Is maintained in a single shared Electronic Health Record (EHR)/ clinical record that is accessible across the treatment team to ensure coordination of care planning. • Outcomes are evaluated and monitored for quality and safety for each patient.
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.

Check, if applicable	Description of Core Components
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)

The objectives of this project are well-aligned with UCIMC's organizational goal to transform our outpatient care delivery system into a more efficient, better-coordinated, and patient-centered model of care. Our planned approach to designing and implementing the project includes the following:

- UCIMC will develop the methodology for a gap analysis of our practice sites utilizing our electronic record systems We plan to undertake this in DY11 and DY12
- Based on the gap analysis results UCIMC will identify our needs for non-licensed personnel. Reporting structure(s) for non-licensed personnel will be created or updated as needed to ensure high-functioning, high-quality, and collaborative work teams. A well-trained and highly competent workforce will be created using an organized onboarding and continuous competency validation and training plan. We plan to initiate this component in DY11 and expand upon it in subsequent years.
- To meet the access demands for both face to face and non-face to face care coordination UCIMC will establish a non-licensed frontline workforce to be responsible for coordination of clinical and non-clinical services and care services. We plan to begin building upon our current workforce in DY 12 and DY13. We will continue to expand the workforce to align with our growth and expansion of services in DY14 and DY15.
- A population health management tool will be developed and implemented. The tool will allow for improved management of panel sizes and assignments, support care delivery and achievement of preventive health and chronic disease metrics. The tool will enhance care delivery for mental health and substance abuse patients. We plan to integrate the tool into care delivery in DY14 and DY15.

Target Population: The UCIMC target population identification for this project will occur in agreement with the PRIME Special Terms and Conditions criteria, including all established and assigned primary care patients. Sub-groups of the overall target population will be identified by diagnosis, risk stratification and patient engagement assessments for participation in targeted improvement initiatives.

Vision for Care Delivery: PRIME will create a platform and organized direction from which UCIMC can transform our outpatient care delivery system for primary care patients into a more efficient, better-coordinated and patient-centered model of care. By redesigning care, our vision is to leverage new technologies to expand primary care access and improve quality of care through development of preventative health care models, better identification and management of chronic disease populations, and enhanced support for patients with mental health and substance abuse disorders. Ultimately creating a network of care delivery and support that enables system to promote health in healthy patients, provide high quality, effective care for medically and mentally labile patients in our ambulatory settings, when appropriate, and redirect the burden of access needs from hospital and emergency services to outpatient care.

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.
Not Applicable	**1.2.2** Primary care practices will demonstrate advancement of their PCMH transformation through the use of a nationally-recognized PCMH methodology.
Applicable	**1.2.3** Hiring and training of frontline workforce (e.g., medical assistants, community health workers, promotoras, health navigators or other non-licensed members of the care team) to be responsible for coordination of non-clinical services and elements of the care plan.
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 Applicable	**1.2.6** Enable prompt access to care by: • Implementing open or advanced access scheduling. • Creating alternatives to face-to-face provider/patient visits. Assigning frontline workers to assist with care navigation and non-clinical elements of the care plan.

Check, if applicable	Description of Core Components
Applicable	**1.2.7** Coordinate care across settings: • Identification of care coordinators at each primary care site who are responsible for coordinating care within the PCMH as well as with other facilities (e.g., other care coordinators or PCMH/DPH/DMPH high risk care managers): o Establish onsite care/case managers to work with high risk patients and their care teams, or develop processes for local care coordinators to work with a central complex care management program for these patients Implement processes for timely bi-directional communication and referral to specialty care (including mental health and substance use disorder services), acute care, social services and community-based services.
Applicable	**1.2.8** Demonstrate evidence-based preventive and chronic disease management.
Not Applicable	**1.2.9** Improve staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the team-based care model to ensure effective and efficient provision of services (e.g., group visits, medication reconciliation, motivational interviewing, cognitive behavioral therapy and Medication-Assistance Treatment (MAT)).
Not Applicable	**1.2.10** Engage patients using care plans, and self-management education, and through involvement in the design and implementation of this project.
Not Applicable	**1.2.11** Improve the accuracy and completeness of race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI) data, and use that data to identify and reduce disparities in one or more Primary Care Redesign project metrics by: • Adding granular REAL and SO/GI data to demographic data collection processes and training front-line/registration staff to gather complete and accurate REAL/SO/GI data. • Developing capacity to track and report REAL/SO/GI data, and data field completeness. • Implementing and/or refining processes for ongoing validation of REAL/SO/GI data. • Developing capacity to stratify performance metrics by REAL/SO/GI data and use stratified performance data to identify disparities for targeted interventions. • Developing capacity to plan and implement disparity reduction interventions with input from patients and community stakeholders. • Developing dashboards to share stratified performance measures with front-line staff, providers, and senior leadership.

Check, if applicable	Description of Core Components
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)

Specialty care plays a critically important role in our academically-focused outpatient care setting at UCIMC. This project supports our efforts to provide seamless coordination of care with the patient's primary care provider and increase access to our specialty practice clinics. We expect that improvements in these areas will improve patient experience and clinical outcomes, as well as decrease utilization of emergency department services due to inability to access specialty providers in the clinic setting.

Our planned implementation approach includes:

- *Referral processes*: We will perform a gap analysis in DY 11/DY 12 to identify barriers to timely scheduling of specialty visits. An improvement strategy will be piloted and new processes instituted broadly with measured results in subsequent years.
- *Immunizations:* We will develop an influenza project that assures all providers, including specialists, access and provide influenza immunizations. Often specialty practices see the administration of vaccines for influenza as a primary care clinic responsibility. We will identify strategies to ensure specialists identify patients in need of influenza vaccine and administer it during those visits.
- *Care paths:* The UCIMC Emergency Department collaborates with specialty care representatives to develop care paths to reduce hospital readmissions in high risk groups. Identification of patients at high risk for readmission often occurs in the emergency department. Care paths to treat high risk populations can provide directed care in the outpatient setting which prevents readmissions.

Target Population: Because specialty care is so broad we have identified high-volume populations for special focus. These populations include patients with a diagnosis and treatment plan for cancer, cardiovascular disease, and/or gastrointestinal disorders.

Vision for Care Delivery: High-quality, patient-centered care requires coordination and communication between the specialist, primary care provider and the emergency department. The development of standard processes and resources will assist in improving the provision of care for our most vulnerable 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 to meet that need. Benchmark to other CA Public Health Care systems.
Applicable	**1.3.3** For ideal state analysis, include potential impact of increased primary care capacity to manage higher acuity conditions either independently, or in collaboration with, specialty care, so as to reduce the need for in-person specialty care encounters (e.g., insulin titration, IBS management, joint injections, cognitive behavioral therapy (CBT) or MAT).
Applicable	**1.3.4** Engage primary care providers and local public health departments in development and implementation of specialty care model.
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.
Not 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.
Applicable	**1.3.10** Develop and implement standardized workflows for diversified care delivery strategies (e.g., shared medical visits, ancillary led services, population management, telemedicine services) to expand access and improve cost efficiency.
Applicable	**1.3.11** Adopt and follow treatment protocols mutually agreed upon across the delivery system.

Check, if applicable	Description of Core Components
Not Applicable	**1.3.12** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population management activities and care coordination/transitions of care. Ensure that timely, relevant, and actionable data are used to support patient engagement, PCP collaboration, and drive clinical, operational and strategic decisions including continuous quality improvement (QI) activities.
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.

☒ 1.4 – Patient Safety in the Ambulatory Setting

UCIMC has selected this project as patient safety is an integral part of a patient-centered, holistic model of care utilized in our ambulatory clinics. Improving patient safety in the ambulatory setting supports our organizational efforts to minimize preventable morbidity and mortality associated with medication errors, ineffective communication and missed/delayed diagnosis or treatment.

Our planned implementation approach includes:

- *Baseline study*: In DY 11/DY 12 we will perform a gap analysis of abnormal results follow-up workflow and monitoring of patients on medications for chronic disease to identify any process flaws. An improvement strategy based on the gap analysis results will be piloted and new processes expanded to additional clinics in subsequent years.
- *Transformation:* We will redesign current processes and create or amend standardized procedures related to patient safety as needed to address current variations in care standards and processes across ambulatory clinics at UCIMC. Frontline staff, faculty and patients will be engaged to assist and participate in clinical transformation efforts to achieve future state workflows and improvements.
- *Technology:* Developing and implementing improved processes will be supported by improvements in the electronic medical record and other technology involved whenever possible, to provide timely and accurate notification of abnormal results, and standardize monitoring of patients on persistent medications.

Target Population: Improvement initiatives will begin with targeted pilot clinics based on gap analysis findings, with expansion to all ambulatory clinics in subsequent years. The target population for metrics will include the subsets of primary care and assigned patients who have had diagnostic testing abnormal results or who require annual monitoring related to specific medications for chronic conditions.

Vision for Care Delivery: We aspire to reliably and appropriately provide abnormal result follow-up and monitoring of patients on persistent medications in a timely fashion. Integrating standard workflow processes to ensure that these goals are achieved will contribute to the overall care of our patients, and avoid harm caused by preventable morbidity and mortality.

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

Check, if applicable	Description of Core Components
Applicable	**1.4.1** Perform a baseline studies to examine the current workflows for abnormal results follow-up and monitoring of individuals on persistent medications.
Not Applicable	**1.4.2** Implement a data-driven system for rapid cycle improvement and performance feedback based on the baseline study that effectively addresses all identified gaps in care and which targets clinically significant improvement in care. The improvement and performance feedback system should include patients, front line staff from testing disciplines (such as, but not limited to, radiology and laboratory medicine) and ordering disciplines (such as primary care) and senior leadership.
Not Applicable	**1.4.3** Develop a standardized workflow so that: • Documentation in the medical record that the targeted test results were reviewed by the ordering clinician. • Use the American College of Radiology's Actionable Findings Workgroup[1] for guidance on mammography results notification. • Evidence that every abnormal result had appropriate and timely follow-up. Documentation that all related treatment and other appropriate services were provided in a timely fashion as well as clinical outcomes documented.
Not Applicable	**1.4.4** In support of the standard protocols referenced in #2: • Create and disseminate guidelines for critical abnormal result levels. • Creation of protocol for provider notification, then patient notification. • Script notification to assure patient returns for follow up. Create follow-up protocols for difficult to reach patients.
Applicable	**1.4.5** Implement technology-enabled data systems to support the improvement and performance feedback system as well as engage patients and support care teams with patient identification, pre-visit planning, point of care delivery, and population/panel management activities.

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

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)

UCIMC is the only Perinatal-Neonatal Center in Orange County and as such serves a larger percentage of high-risk pregnant patients compared to other perinatal centers in the county. Embarking in this project will allow UCIMC to address challenges with continuum of care fragmentation and provider-dependent variability in care. Additionally, through this project UCIMC plans to improve processes and accountability in order to prevent complications that have the potential to result in maternal morbidity and mortality.

The UCIMC planned implementation approach includes:

- *Creation of a Perioperative Surgical Home (PSH) team***.** The PSH practice model for perinatal services begins from the point when the decision for Caesarean-section is made, and continues until 30 days post discharge of the patient from the hospital. The goals of the PSH model are multi-departmental and include:
  - *Improved*:
    - Efficiency
    - Quality and consistency of care
    - Clinical outcomes
    - Transitions of care
    - Surgeon satisfaction
    - Patient experience
  - *Decreased:*
    - Cost of care
    - Complications
    - Length of stay

We will begin the creation of the PSH Perinatal team at UCIMC in DY 11. The team will be multidisciplinary and include team members from Nursing, Obstetrics, Maternal-Fetal Medicine, Anesthesia, Pediatrics and other support staff from inpatient and outpatient settings that provide prenatal, intrapartum and postpartum care.

- *Care Paths and Standards of Care.* Project team members will work with the PSH Perinatal team to develop evidence-based clinical care pathway(s), standard order sets and multidisciplinary team education as appropriate for Caesarean-sections and other perinatal care needs identified across the inpatient and outpatient setting.
- *Care Coordination*. A gap analysis of care provision for women in the post-partum period with co-morbid conditions including diabetes and hypertension will be completed in DY 11 and DY 12, and improvement strategies planned for subsequent years.

Target Population: Our target population will include all established and assigned primary care patients with a pregnancy episode of care. Specific interventions (e.g. PSH for Caesarean-sections) will focus on a subset of the larger target population.

Vision for Care Delivery: The Perinatal Care PRIME project will create the opportunity for UCIMC to transform our perinatal inpatient and outpatient care to provide more evidence-based, consistent care that promotes the highest quality of care and patient experience. We plan to achieve this vision by maintaining a Baby Friendly Hospital organization, focusing efforts to improve communication and care coordination through the implementation of the Perioperative Surgical Home for perinatal surgeries, and advancing care coordination of patients with comorbidities during pregnancy episodes of care.

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

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

Check, if applicable	Description of Core Components
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)

UCIMC selected this project because, as an organization, we are committed to removing any barriers to coordination across the care continuum. Reducing preventable readmissions within 30 days of inpatient discharge is a means of measuring the quality, patient safety and success of the discharge plan. Critical areas of opportunity for improvement within our organizational infrastructure include improving communication and medication reconciliation as patients transition from inpatient to outpatient care settings.

Our planned implementation approach includes:

- *Patient Identification:* All unplanned readmissions may not be preventable. To most efficiently utilize resources, UCIMC will identify patients for whom targeted interventions will potentially prevent a readmission. This will be accomplished by utilizing predictive analytics to proactively identify hospitalized patients who are at high risk for potentially preventable readmission. This patient population will be a subset of the overall PRIME patient population and will receive targeted interventions to reduce readmission risk. We expect to undertake this work in DY11 and DY 12.
- *Standardized Workflow – Inpatient:* We will convene a group of subject matter experts to review/ assess the current inpatient discharge process, with a particular focus on medication reconciliation (upon admission and at time of discharge). We will identify resources to support readmission reduction and develop processes to optimize the inpatient discharge flow. We anticipate beginning this work in DY12 with implementation in DY 13.
- *Standardized Workflow – Outpatient:* We will convene a task force to assess current state of the initial post-discharge outpatient visit, including, but not limited to, timely availability of post-discharge appointment and medication reconciliation. These actions will be developed and implemented across a standardized process. We expect to undertake this work in DY 12 with implementation in DY 13.
- *Integration of post-acute services:* We will collaboratively work with external providers (Home Health Agencies, Skilled Nursing Facilities, etc.) to:
    - Improve communication via standardized protocols for on-going post-discharge communication

        - transmission of the discharge summary to post-discharge care providers
        - process for primary care providers to receive updates from Home Health)
    - Improve access to post-acute services including specialty services
        - develop streamlined processes for specialty services referrals
        - create a process to ensure patients are provided with post-acute service provider contact information)

Target Population: Our target population will be determined by the PRIME Special Terms and Conditions criteria to include established or assigned UCIMC primary care patients who are discharged from the hospital.

Vision for Care Delivery: PRIME will enable UCIMC to further implement our vision to build a more integrated organization, support accountability and facilitate timely communication in the delivery of high quality patient-centered care across the care continuum. The measures described above will provide the infrastructure to support targeted interventions in this patient population with the goal to reduce potentially preventable readmissions.

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.
Not Applicable	**2.2.2** Establish or expand on a system to track and report readmission rates, timeliness of discharge summaries, and other transition processes, and investigate system-specific root causes/risk factors for readmission, using quantitative and qualitative information to identify the key causes of readmissions, including physical, behavioral and social factors.
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.

<table>
<tr><th>Check, if applicable</th><th>Description of Core Components</th></tr>
<tr><td>Applicable</td><td>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:

Involve mental health, substance use, pharmacy and palliative care when possible.
Involve trained, enhanced IHSS workers when possible.
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.</td></tr>
<tr><td>Not Applicable</td><td>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.</td></tr>
<tr><td>Applicable</td><td>2.2.6 Develop standardized workflows for post-discharge (outpatient) care:

Deliver timely access to primary and/or specialty care following a hospitalization.
Standardize post-hospital visits and include outpatient medication reconciliation.
</td></tr>
<tr><td>Not Applicable</td><td>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.</td></tr>
</table>

Check, if applicable	Description of Core Components
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)

UC Irvine Health selected this project because establishing a complex care management infrastructure will enable us to improve care for patients across the enterprise. We intend to undertake the following core components within the identified timeframes in our approach to designing and implementing the project:

- UC Irvine will identify target populations and develop program inclusion criteria based on quantitative and qualitative data (e.g. CCI indices, polypharmacy, and lace scores). Based on our findings, we will develop uniform definitions to be used. We expect to undertake this work in DY11.
- We will establish data analytics systems using clinical data sources (EHR, Data 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. We expect to establish analytics systems that will allow us to risk stratify high risk medical populations in DY11 and DY12.
- We will develop a multi-disciplinary team, to which each participant is assigned, that is tailored to the target population and whose interventions are tiered according to patient level risk. We expect to design this approach by DY12 and implement the process by DY13.

- As part of the overarching plan we will ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team function and care management care sets. We expect to develop the training, coaching, and monitoring methodology in DY12, and implement the approach by DY13.
- We will more fully integrate and optimize care management services across our primary care sites. This includes:
  - Expansion of UCIMC's structured diabetes and heart failure education programs led by Registered Nurses (RN) and Registered Dietitians (RD)
  - Optimized nutritional counseling for diabetes, cardiac and renal patients using Registered Dietitians and Certified Diabetes Educators (RN and RD)
  - Ambulatory Pharmacist-led programs to develop and expand services for polypharmacy patients and patients on high-risk medications
  - Development and integration of multi-disciplinary care coordination services that will utilize cognitive behavioral therapists, health coaches, social workers and nurse navigators/care coordinators to provide healthcare navigation services and promote patient engagement and activation.

Target Population: Our target population will be determined by applying the PRIME Special Terms and Conditions criteriato diagnosis and utilization data to identify patients whose care is established with UCIMC and who have multiple comorbidities or complex treatment regimens.

Vision for delivery of care: Our vision is to develop a complex care management program that will improve our ability to support patients with medically complex heart failure and diabetes who are at risk of unnecessary Emergency Department use and avoidable readmissions in the absence of coordinated multi-disciplinary support. Our program will aim to improve care management and care coordination of this fragile ambulatory population through improved identification, optimization and integration of health care support systems which include improved access to our Medication Safety/Polypharmacy Clinic, ambulatory pharmacist care, dietary counseling, structured diabetes education, social worker interventions and care, and enhanced access to behavioral health and health coaching services.

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.

Check, if applicable	Description of Core Components
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.
Not Applicable	**2.3.6** Develop a multi-disciplinary care team, to which each participant is assigned, that is tailored to the target population and whose interventions are tiered according to patient level of risk.
Applicable	**2.3.7** Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets.
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: • 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.

Check, if applicable	Description of Core Components
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

UCIMC selected this project to improve pain management provider and care teams' ability to identify and manage chronic pain using a multi-modal approach, and to improve outcomes by distinguishing between patients who will benefit or likely to be harmed by opioid use and misuse.

Our planned project approach includes the following:

- Implement protocols for pain management of patients with chronic pain including:
    1. A standardized Pain Care Agreement
    2. Standard policies and work flow for safe prescribing of opioids
    3. Develop a comprehensive evaluation including psycho-social evaluation, pain medication risk/benefit, informed consents, ongoing monitoring of planned outcomes and behavior screening and management.
    4. Develop guidelines for maximum acceptable dosing
- Coordination of a chronic pain care team that minimally consists of a physician champion and medical support staff.
- Development of analytical tools for data collection.
- Scheduling process improvements to ensure follow up appointments and medication refills are completed in a timely manner while monitoring for signs of diversion or misuse.

Target Population: Our target population determined by the PRIME Metric definitions is a subset of our primary care and assigned Medi-Cal managed care patients including new patients with chronic pain on opioid therapy seen in the UCIMC pain management practice.

Vision for delivery of care: The vision of is to enhance the quality of life of patients by not only decreasing their pain, but providing a multi focal approach to the care of the patient on opioid therapy by utilizing the least amount of opioid still maximizing benefit and minimizing risk. Our program will aim to standardize protocols and guidelines in the management of the chronic pain population with a multi-disciplinary approach to the delivery of their care. The overall goal is to improve the quality and function of patients 18 years and older with chronic pain.

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

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

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

☒ 3.1 – Antibiotic Stewardship

We selected this project because of the significant need to improve antibiotic use at UCIMC. Up to 50% of all antibiotic use is unnecessary or inappropriate and leads to the development of drug resistant bacteria and *Clostridium difficile* (*C. difficile*) colitis. Like other healthcare facilities in recent years, UCIMC has seen an increase in antibiotic resistant bacteria, and *C. difficile* rates at UCIMC are the highest in Orange County. Hence, it is imperative that the selection and the duration of antibiotics be further optimized. In addition, it is critical to avoid antibiotic use when unnecessary.

We plan on focusing on the core components chosen below through the achievement of the following five metrics:

1. **Avoidance of antibiotic treatment in adults with acute bronchitis.**

   Baseline rates of patients who were prescribed antibiotics within 3 days of a diagnosis of acute bronchitis in a selected clinic will be measured. We plan to improve on this metric through directed education of health care providers in the ambulatory setting.

2. **Avoidance of antibiotic treatment with low colony urinary cultures.**

   We will implement strategies to reduce the antibiotic treatment of urine cultures that are less than 50,000 CFU/ml. Year 1 will be dedicated to measure baseline rates of antibiotics prescribed for urine cultures with 50,000 CFU/ml. We will then improve on this metric by selective reporting of microbiological results and education of health care providers on the lack of clinical significance of low colony urinary cultures.

3. **Prophylactic antibiotics discontinued at time of surgical closure.**

   Based on the CDC's extensive literature review, high-quality evidence suggested no benefit of continuing prophylactic antibiotics after intraoperative closure of the surgical incisions. We will collaborate with lead surgeons at UC Irvine Health to build a practice consensus to discontinue prophylactic antibiotics at the time of surgical closure for non-cardiothoracic clean procedures, even in the presence of a drain as recommended by the CDC (Category IA). Subsequently, we will hard-wire discontinuation of prophylactic antibiotics at the time of surgical closure utilizing computerized order sets combined with education of staff involved.

4. **National healthcare safety network antimicrobial use measure.**

   Two classes of antibiotics, anti-pseudomonal anti-lactam drugs and anti-MRSA agents, will be measured by days of therapy (DOT). Reduction of DOT of these antibiotics will be achieved by requiring clearance of certain agents, prospective review and audit, antibiotic time out, and education.

5. **Reduction in hospital acquired *Clostridium difficile* infections.**

We hope to reduce the rate of hospital acquired *Clostridium difficile* infections through general reduction in broad spectrum antibiotic use, optimizing parameters for *C. difficile* testing, and maximizing infection control practices.

Target Population: PRIME metric definitions will be applied to electronic medical record data to determine populations for individual measures, but interventions to improve care will be applied to all patients with respect to antibiotic use and stewardship.

Vision of Care Delivery: By focusing on the core components and meeting the outlined metrics, care will be improved by decreasing patient exposure to unnecessary antibiotics. Thus, the incidence of toxicities due to antibiotics such as allergic reactions, kidney and liver dysfunction, and cardiac arrhythmias will be reduced. Most importantly, avoidance of excessive antibiotic use will decrease the rates of *C. difficile* colitis and the development of drug resistant bacteria.

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

Check, if applicable	Description of Core Components
Not Applicable	**3.1.1** Utilize state and/or national resources to develop and implement an antibiotic stewardship program, such as the California Antimicrobial Stewardship Program Initiative, or the IHI-CDC 2012 Update "Antibiotic Stewardship Driver Diagram and Change Package."[2] • Demonstrate engagement of patients in the design and implementation of the project.
Not Applicable	**3.1.2** Develop antimicrobial stewardship policies and procedures.
Not Applicable	**3.1.3** Participate in a learning collaborative or other program to share learnings, such as the "Spotlight on Antimicrobial Stewardship" programs offered by the California Antimicrobial Stewardship Program Initiative.[3]

[2] The Change Package notes: "We do not recommend that any facility attempt to implement all of the interventions at once. There are a large number of interventions outlined in the Change Package, and attempting to implement too many at one time will likely create huge challenges. Rather, the Change Package is meant to serve as a menu of options from which facilities can select specific interventions to improve antibiotic use." (p. 1, Introduction).

[3] Launched in February 2010, this statewide antimicrobial stewardship program expands use of evidenced-based guidelines to prevent and control infections and improve patient outcomes: Click here to see this statistic's source webpage.

Check, if applicable	Description of Core Components
Not Applicable	**3.1.4** Create standardized protocols for ordering and obtaining cultures and other diagnostic tests prior to initiating antibiotics.
Not Applicable	**3.1.5** Develop a method for informing clinicians about unnecessary combinations of antibiotics.
Applicable	**3.1.6** Based on published evidence, reduce total antimicrobial Days of Therapy (DOT) by providing standards and algorithms for recommended agents by disease type, focusing on short course regimens (e.g., 3-5 days of therapy for uncomplicated cystitis, 7 days for uncomplicated pyelonephritis, 5-7 days for uncomplicated non-diabetic cellulitis, 5-day therapy for community acquired pneumonia (CAP), 7-8 days for therapy for VAP or hospital acquired pneumonia).
Not Applicable	**3.1.7** Develop evidence-based computerized provider order entry (CPOE) algorithms and associated clinician training, to support antibiotic stewardship choices during order entry. These could include approaches such as guidelines for duration of antibiotics, within drug class auto-switching for specific antibiotics and doses, or restriction of specific antibiotics at the point of ordering (e.g., broad spectrum agents).
Not Applicable	**3.1.8** Implement stewardship rounds focusing on high yield drugs to promote de-escalation after the drugs are started, such as regular antibiotic rounds in the ICU.
Applicable	**3.1.9** Improve diagnostic and de-escalation processes to reduce unnecessary antibiotic use based upon length of therapy or antibiotic spectrum, such as: • Procalcitonin as an antibiotic decision aid. • Timely step-down to oral antibiotic therapy to support early discharge from the hospital for acute infections. • Use of oral antibiotics for osteomyelitis to reduce prolonged IV exposures.
Not Applicable	**3.1.10** Evaluate the use of new diagnostic technologies for rapid delineation between viral and bacterial causes of common infections.
Applicable	**3.1.11** Adopt the recently described "public commitment" strategy in outpatient clinics to encourage providers not to prescribe antibiotics for upper respiratory tract infections (URIs).

Check, if applicable	Description of Core Components
Applicable	**3.1.12** Publish organization-wide provider level antibiotic prescribing dashboards with comparison to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.
Not Applicable	**3.1.13** Implement a system a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

Please complete the summary chart:

	For DPHs	For DMPHs
Domain 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 $ 36,426,600
- DY 12 $ 36,426,600
- DY 13 $ 36,426,600
- DY 14 $ 32,783,940
- DY 15 $ 27,866,349

Total 5-year prime plan incentive amount: $ 169,930,089

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.