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

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

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General Instructions

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

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

Scoring

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

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

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

Section 1: PRIME Participating Entity Information

Health Care System/ Hospital Name: Santa Clara Valley Health and Hospital System (SCVHHS)

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.

Santa Clara Valley Health and Hospital System (SCVHHS) is located in the city of San Jose, California, within Santa Clara County. San Jose is the third largest city in the state and the largest city in Santa Clara County. Santa Clara County is the sixth most populated of California's 58 counties and the most populated county in the San Francisco Bay Area. The health care needs and disparities of our community are summarized below.

Physical Health. The most significant health issues facing our community include cancer, diabetes, heart disease and stroke.

- Cancer and heart disease were the leading causes of death in both males and females, accounting for half of all deaths in the County. The third most common cause of death for females is Alzheimer's disease; for males it is unintentional injuries.

- Over half of adults and one-third of adolescents in the county are overweight or obese. In both groups, Latino residents represent the highest percentage.

Behavioral Health. In Santa Clara County, nearly 4 in 10 adults reported poor mental health and 1 in 4 adolescents reported depressive symptoms in the prior year. The Behavioral Health Services Department served 25,000 mental health

and 10,000 substance abuse clients in fiscal year 2015.

Health Disparities. Health care coverage in Santa Clara County is highest for residents who are White (95%) and lowest among Latino residents (70%). Despite 87% of African American residents having health care coverage, one-third report fair to poor health status. Additionally, African Americans have the highest rate of preventable hospitalizations at 466 per 100,000 residents and the highest rate of infant mortality at 6.1 per 1000 live births, exceeding the California rate of 4.7.
Diabetes is present in over 8% of adults, the greatest percentages among Latino (11%) and African-American (10%) residents, with both groups accounting for the highest diabetes-related hospitalizations in the county. Minority groups are disproportionately affected by HIV, as evidenced by the rate of new diagnoses in African Americans at 27.5 per 100,000 residents, which is significantly higher than the overall county rate of 7.9. Nearly two-thirds (65%) of the County's homeless population report one or more health conditions, including: psychiatric/emotional issues (39%), drug or alcohol abuse (38%) and physical disability (30%). Amongst the chronically homeless, 22% receive Medi-Cal/Medicare benefits, compared to 30% of non-chronically homeless, and 54% use the emergency department as a primary source of health care.

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.

SCVHHS serves the diverse population of Santa Clara County, with 1.8 million residents and an estimated daytime population of 2 million. Santa Clara County has one major city center, San Jose, which is home to over 50% of the county's residents.

Income. Santa Clara County has the highest median household income in the nation, at $93,500, yet this wealth has created a widening gap between high earners and middle- and low-income workers. Over half of the households in Santa Clara County earn $75,000 or more per year. However, only 13 percent of the county's households are in the $50,000-to-$74,000 per year range, while 15 percent in the $25,000 to $50,000 range and almost 14 percent in the less than $25,000 range.

Race/Ethnicity and Language. The ethnic makeup of Santa Clara County is: 56% White, 35% Asian, 26% Hispanic, 2.9% African American, 1.3% Native American, and 0.5% Pacific Islander. Other races constitute 12.4% of the population, with 4.9% of persons reporting being from two or more races. More

than one-third (37%) of residents are foreign born. Nearly a majority of Santa Clara County residents speak a language other than English at home, with Spanish being the most common, followed by Chinese, Vietnamese, Tagalog, and Korean.

Age. Santa Clara County's population is aging. In 2010, the proportion of residents, age 65 years and over, was 11% but is expected to grow to 23% by 2060.
Currently, age is stratified as follows:

- 0-18 years (29%)
- 19-64 years (59%)
- 65 and over (12%)

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.

SCVHHS is dedicated to the health and well-being of all communities in Santa Clara County. SCVHHS is comprised of Santa Clara Valley Medical Center (SCVMC) and Ambulatory Care Clinics, Behavioral Health Services Department, Public Health Department, Custody Health Services and Valley Health Plan.

SCVMC is a 574-bed acute care teaching hospital and research institution. SCVMC is the "safety net" for every resident in our community with seamless access to high-quality, specialized services, in some cases the only such treatment in the region, closely coordinated with primary care. Moreover, SCVMC is the only medical center in the region that provides highly specialized care including a world- class Rehabilitation Center, Regional Burn Center, High-Risk Maternity Program, and a Level 1 Trauma Center.

SCVMC has a network of ten Ambulatory Care clinics providing an extensive array of health care services through its Valley Specialty Center supported by four medical and dental mobile units. These clinics, known as Valley Health Centers (VHCs), are located throughout Santa Clara County and offer Pediatrics, Obstetrics/Gynecology, Adult Medicine, Geriatrics, Dental, Urgent Care, and selected adult and pediatric specialties. Sites include VHC Moorpark, VHC Tully, VHC Gilroy, VHC Sunnyvale, VHC East Valley, VHC Milpitas, VHC Lenzen, VHC Bascom, VHC Alexian and VHC HomeFirst. A newly constructed clinic will be added to the clinic network in mid-2016 to support the Downtown San Jose region and surrounding communities. In Fiscal Year 2015, SCVHHS had 120,200 acute inpatient days and 803,818 ambulatory care visits, with a payer mix of: 40% Medi- Cal, 23% managed care, 19.1% Medicare, 13.4%

private insurance, and 4.5% unsponsored.

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.

SCVHHS has an Enterprise electronic health record (EHR) software with robust reporting capabilities installed in most of the PRIME related areas. Utilizing this system, we plan to discretely capture the PRIME data elements. One of our guiding principles for PRIME is that our ability to track data for large populations requires a transition away from manual "scrubbing" of data and toward reliance ondiscrete data capture. One limitation of our baseline data is that we expect some data elements may not be entered discretely due to lack of established workflows or lack of end user training. Our improvement efforts over the next five years will include establishing standardized workflows for discrete data capture and ensuring adequate education to support discrete, standardized data entry. Such standardization of data entry and automation of reporting will allow the Transformation Coordinators to spend less time on manual scrubbing of data and more time working directly with our PRIME project teams to improve progress on core components and performance on required metrics.

We have contracted with three report writers to support the nine PRIME project teams to design, build and validate PRIME baseline reports and reporting dashboards. Additionally, our EHR analysts will be developing tools for patient outreach, risk scoring, and care coordination for use by our Population Health Coordinators. We anticipate barriers in clinical areas that do not use our enterprise EHR, which includes custody/jail and portions of behavioral health. Reporting from these areas will initially prove more difficult and will lack the enhanced care coordination tools of our EHR. In the short term, we will rely on our data warehouse to aggregate any outside data, including jail/custody and behavioral health. Long term, we will complete our EHR rollout to behavioral health and jail/custody by summer 2017, at which point we will have a fully integrated system utilizing one EHR platform.

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.*

   The vision of SCVHHS is to achieve "Better Health for All" through an integrated public health system, capable of continuously assessing the needs of the population and delivering efficient, patient-centered and cost-effective care. All aspects of the Waiver align with SCVHHS's strategic goals, which target: system integration, accountability and transparency, staff engagement and development, unified coordination of care, improvement of the overall patient experience and community transformation. As part of PRIME, SCVHHS intends to focus on developing processes that improve and innovate our capability to provide a whole-person care approach that is responsive to our patients' needs as they move throughout the health and hospital system.

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.*

   SCVHHS has several aims for PRIME participation. SCVHHS will expand on DSRIP's framework of integrated care, registries and measurable performance improvement to address complex care management and ensure seamless coordination of services. Through continual monitoring, patients who are not meeting goals can be identified earlier and interventions customized to the

individual needs of the patient. SCVHHS will focus on successfully integrating services, including primary care, specialty care, behavioral health and mental health, so that our patients/clients have one EHR and care plan that addresses the patient/client's complete needs, and in a manner that best serves the individual patient. The patient-focused care that utilizes the full range of services offered is the transformation SCVHHS envisions and desires. Through this model, we can improve the health and well-being of our community, as we simultaneously improve care delivery for the individual.

3. *Provide a statement of how the selected projects will support the identified goals and specific aims. Note that the narrative should connect the specific aims identified in Section 3.1.2 to the projects you select in Section 4. Each project does not require a specific statement. Instead, the narrative in the abstract is broadly linking projects to identified goals and specific aims;*

The vision and strategic goals of SCVHHS is to achieve an integrated health system that will systematically assess and improve the needs of the community via timely access to high-quality and efficient patient-centered, cost-effective and holistic approach of care. Through the required projects, SCVHHS intends to replace fragmented systems of care with a fully-integrated care coordination and infrastructure and address the multiple health needs of our population in a more comprehensive and coordinated manner. Integrating behavioral health and primary health will transform SCVHHS primary care outpatient delivery system, allowing SCVHHS early identification and interventions, reduce delays in treatment, and will ensure that patients have improved access for better preventative and specialty care. Aggregation of patient data via a population health management registry will allow SCVHHS providers to have all patient data together for an improved clinical and financial outcome. Above all, SCVHHS anticipates these interventions will diminish barriers to achieving social determinants of health. The optional projects will also share much of the infrastructure improvement planned for the required projects, which will provide more opportunity to evaluate the success of our integration efforts across service lines. Additionally, given the higher level of specificity required to track patients in these projects, SCVHHS anticipates there will be robust informaion to guide improvements in our patients' EHR, which will be a key communication tool supporting unified, patient-centered care.

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

   The selected projects interrelate by addressing key transformation and process improvement that can be applied similarly to the required projects. Additionally, activities surrounding the selected projects will allow SCVHHS to achieve greater outcomes in physical and behavioral health integration and outpatient care, which provide value to the patient, improves their level of satisfaction and maximizes efficient utilization of resources. The demands for continued performance improvement will require smarter investments, better information and efficient coordination of care. Risk- and value-based payments force system and care modifications that will deliver the desired outcomes of improved health and patient experience and lead to financial sustainability.

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.*

   By 2020, SCVHHS anticipates that improvements through PRIME will result in our successful transition into regionally developed, integrated health system, focused on whole person care that has responsibility for the vast majority of the Medi-Cal Managed Care Lives in Santa Clara County. In addition, there will be a significant increase in other payer (i.e., Commercial/Covered CA, Medicare) market share and utilization of both hospital-based inpatient and outpatient services, particularly in the area of specialized and regional services, including: Rehabilitation, Burn, Trauma, Cancer Care, and Women & Children Services. SCVHHS will achieve this through a robust network of primary care and outpatient services, focused on individualized care (physical and behavioral), whole person care, and targeted health outcomes. The system will have advanced analytics and reporting capabilities that help focus and drive improvement in patient care and outcomes. Collectively, this will result in a financially viable and self-sustainable public health delivery system that can care for all Santa Clara residents, and successfully transition managed-care payments to alternative methodologies.

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.

Improving access to integrated care that is responsive to the health needs of our community, as described in Section 2.1, will be a common focus for each of the selected projects. SCVHHS expects that the process improvements, achieved under the Waiver, will not only benefit our PRIME population but will allow foundational changes that positively impact every patient who accesses our system. By leveraging the capacity of our EHR to manage and centralize patient health data, including improved registry management and outcome data, SCVHHS will better equip our providers to connect patients to care and reduce delays in treatment. This will be especially critical when managing care transitions for our most vulnerable patients, including those targeted in our PRIME projects.

In aligning our aims of integrated services, seamless coordination of care, improved data management, and patient-centered care, with selected PRIME projects, SCVHHS ensures that residents of Santa Clara County will have improved access for better preventative and specialty care and are provided opportunities to participate in and drive their health outcomes.

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).

SCVHHS' five-year strategic plan is intended to lead our work through PRIME projects and align operations so that SCVHHS can increase its market share in an intentional way to become financially viable. Our strategic plan addresses quality of care, access, customer satisfaction, financial responsibility, and population health improvement goals that provide foundational structure for improved health and delivery system redesign by the end of the Waiver in 2020.

In 2015, SCVHHS established an HHS Waiver Integration Team (WIT), comprised of the Executive Team and Directors from the hospital and clinics, which meets regularly to oversee all of the Medi-Cal 2020 initiatives, manage infrastructure needs and communicate with the Board of Supervisors. A Waiver Manager position was created to oversee the PRIME projects and keep the HHS WIT group informed of progress. Each of the nine PRIME projects, selected by SCVHHS, is

managed by a team of stakeholders, subject matter experts, and coordinators who are directly involved with the transformation work and data-driven improvement that are required by the PRIME metrics.

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.

SCVHHS is working with health plans, labor unions, community partners, and county partners to develop all Medi-Cal 2020 Waiver applications, including PRIME. We are building on years of close collaboration, including implementation of the Low Income Health Program and Short-Doyle Program, and will strengthen these partnerships through PRIME, Whole Person Care, Global Payment Program, and Dental Transformation Initiatives. PRIME projects require SCVHHS to share data and outcomes with end users, driving work toward more effective collaborative processes and improved outcomes that impact delivery systems for all stakeholders. Improved patient engagement positively impacts health outcomes and contributes to customer loyalty. SCVHHS has adopted the CICare model to standardize communication and interaction with patients system wide, as a means of creating positive partnerships with our patients. In addition, our Patient-Family Advisory Program (PFAP) provides a solid venue to involve patients in PRIME and patient experience initiatives. SCVHHS has recently created Patient-Family Advisory Teams (PFAT), which are in place in our inpatient areas and several clinics. Ultimately, the goal is to have teams in all clinical areas across the system to ensure the consumer's point of view is incorporated into the delivery of care. Patients and families will continue to be a primary contributor for our system improvement.

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.

SCVHHS has a longstanding commitment to cultural competence and consistently works to train staff on cultural sensitivity and understanding. We have also embarked on improving LGBTQ competence system-wide, to include aligning care with sexual orientation and gender identity (SO/GI) goals. To better respond to the health needs of our multicultural and diverse population, we have developed a language services staff that provides translation into 185 different

languages. SCVHHS seeks to hire staff from many cultures and countries to increase overall cultural competence and strengthen our ability to provide appropriate options to patients. Our Public Health Department conducts regular community health surveys (Latino, Vietnamese, African/American, LGBTQ, etc.), which include specific recommendations to address disparities. SCVHHS utilizes these results by translating them into policy and action in order to address the disparities. Policy development will be informed through PRIME projects, especially as improvement processes identify factors that create disparities in access and prevalence of chronic conditions in our County population, as outlined in Section 2.1.

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.

SCVHHS has established a process to ensure project targets and goals are met and results are sustained over time. A highly skilled team of quality improvement facilitators and analysts has been assembled to support the planning and implementation, data analysis and assessment, and continuity of ongoing improvement efforts. Leadership for this group and individual project teams are clearly defined, includes those who will be accountable on a long-term basis, and will be responsible for direction and coordination to assure outcomes and overall effort align with organizational strategic goals and objectives. Adherence to a data plan and rigorous validation facilitates the accuracy of data, a critical element in evaluation and sustainability. Ongoing efforts to consolidate improvement methodologies into a common language are underway to ensure transformation of health care delivery is well-organized, systematic and data-driven to produce meaningful and sustainable improvement in patient-centered outcomes.

Section 4: Project Selection

The PRIME Projects are organized into three Domains:

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

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

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

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

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

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

Instructions

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

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

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

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

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

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

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

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

Summarize your approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words]

For Project 1.1, SCVHHS will review the lessons learned from California's 2010- 2015 Delivery System Reform Incentive Program (DSRIP) to guide expansion, improve and refine the current model of integrated care, and increase integrated services to the required population. SCVHHS will identify the needed infrastructure to support integration across the system and at each clinic site simultaneously.
Planning activities may identify that our system can leverage the existing structure; one that has proven to nurture integration. A structure that works at the Executive level, for system-level strategy, target setting and minimum standardization requirements, and at the clinic level, includes: Clinic Leadership Meetings and monthly Joint Provider meetings for case consultations. These activities will incorporate clearly defined staging of our intended milestones and outcomes that will optimize achievement over the PRIME timeline.

As a participant of DSRIP, SCVHHS was the only hospital system that elected to implement a Primary Care Behavioral Health Integration project, meeting 100% of the

goals. Improvement efforts involved redesigning four of the system's outpatient adult primary care clinics over the past five and a half years, so the inclusion of this project is welcomed as a required element, thus supporting the continuation of critical transformation work in this area. SCVHHS looks forward to utilizing resources leveraged through PRIME to identify and create the remaining refinements, improvements and expansion the system needs to meet the PRIME goals and aims.

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

Project 1.1 is a fundamental underpinning to the broader goals of Domain 1. Through expanding standardized and regular depression and substance use screening of the eligible patient population, more patients will be identified and their needs addressed earlier. Integrating behavioral health, providing more care coordination services, and utilizing a team care plan as a standard health care practice, will transform our primary care outpatient delivery system. This will allow SCVHHS to identify and address the multiple health needs of our population earlier and more comprehensively. Additionally, this project will drive the modification of our EHR to better serve our population's health needs, by creating Care Team planning templates and utilizing population health registry functions.

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).
Applicable	**1.1.5** Patient-Centered Medical Home (PCMH) and behavioral health providers will: • Collaborate on evidence based standards of care including medication management and care engagement processes. • Implement case conferences/consults on patients with complex needs.
Applicable	**1.1.6** Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families.
Applicable	**1.1.7** Ensure systems are in place to support patient linkages to appropriate specialty physical, mental and SUD services. Preventive care screenings, including behavioral health screenings (e.g., PHQ-2, PHQ-9, SBIRT), will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including the provision of brief interventions (e.g., motivational

Check, if applicable	Description of Core Components
	interviewing techniques) to ensure access for further evaluation and treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.
Applicable	**1.1.8** Provide cross-systems training to ensure effective engagement with patients with MH/SUD conditions. Ensure that a sufficient number of providers are trained in SBIRT and/or in other new tools used by providers to ensure effectiveness of treatment.
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.
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.

Check, if applicable	Description of Core Components
Applicable	**1.1.14** Demonstrate patient engagement in the design and implementation of the project.
Applicable	**1.1.15** Increase team engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on care model.
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)

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]

With an emphasis on achieving the Triple Aim of improving health outcomes, reducing costs and improving patient experience, the Ambulatory Care Redesign of Primary Care project will focus on comprehensive services across the system, with reach into the community. SCVHHS will utilize the whole person care approach to achieve the Triple Aim through coordination of health care, behavioral health and enabling services in a patient centered manner. With this approach in mind, Ambulatory Care's redesign of primary care aims to take care of patients by incorporating essential behavioral health services and enhancing chronic disease management for adults. Building upon the successes achieved under the 2010 DSRIP waiver, SCVHHS will continue to expand the system's capability to respond to patients' needs in a more efficient and individualized manner. Areas of focus for transformation under the PRIME demonstration will include:

1) conducting a thorough system assessment and gap analysis for existing care/case management, care coordination and care navigation services provided to our patients,

2) leveraging current IT systems to identify existing resources and deficiencies and establish standardized processes that provide patients with seamless access to primary care services,

3) conducting a workforce plan assessment to determine the current primary care capacity of the health system, and respond appropriately to hire and train staff in a manner that meets the primary care needs of our patient population, both now and in the future,

4) develop care delivery models based on best practice that fully engages the patient in their own health care to ensure optimal health

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

The whole person care approach will allow for comprehensive care coordination across our system to improve care for patients. Specifically, primary care patients will be assigned to a medical home staffed with a multidisciplinary team consisting of providers, nurses, care managers, social workers and health educators. At the center of the whole person care approach is the patient who is supported by this care team. Patients may have multiple health and social needs which would require the care team to effectively address these specific needs including mental health, medical complexity, and social

issues. A poorly controlled diabetic patient who is in denial about his condition necessitates a different care management approach than a homeless patient with poorly controlled diabetes who lacks a place and skills to store and take his medication. This highly skilled care team will be able to manage and provide this individualized care. The team will have the knowledge and expertise to effectively deal with the patient's primary care needs including preventive health and chronic care needs. With clearly defined roles and responsibilities and staff functioning at the top of their license or scope of practice, the team will be able to develop and implement tools to help them provide care more effectively. Perhaps more importantly, the care team member will be able to develop a trusted relationship with a more engaged patient.

At SCVHHS, empowering employees makes a difference. Frontline employee teams are disseminated throughout the organization as Unit Based Teams (UBTs). UBTs are integral to improving quality outcomes, the patient experience and staff engagement. The teams' recommendations are included in operational decisions impacting their work and they work collaboratively with unions and managers to create an environment in which all employees are encouraged to participate in problem solving, system redesign and innovation. The interest of the UBTs are incorporated into SCVHHS strategic plan.

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

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

Check, if applicable	Description of Core Components
Applicable	**1.2.5** Ongoing identification of all patients for population management (including assigned managed care lives): • Manage panel size, assignments, and continuity to internal targets. • Develop interventions for targeted patients by condition, risk, and self-management status. • Perform preventive care services including mental health and substance misuse screenings and brief interventions (e.g., PHQ-9, SBIRT).
Applicable	**1.2.6** Enable prompt access to care by: • Implementing open or advanced access scheduling. • Creating alternatives to face-to-face provider/patient visits. Assigning frontline workers to assist with care navigation and non-clinical elements of the care plan.
Applicable	**1.2.7** Coordinate care across settings: • Identification of care coordinators at each primary care site who are responsible for coordinating care within the PCMH as well as with other facilities (e.g., other care coordinators or PCMH/DPH/DMPH high risk care managers): o Establish onsite care/case managers to work with high risk patients and their care teams, or develop processes for local care coordinators to work with a central complex care management program for these patients Implement processes for timely bi-directional communication and referral to specialty care (including mental health and substance use disorder services), acute care, social services and community-based services.
Applicable	**1.2.8** Demonstrate evidence-based preventive and chronic disease management.
Applicable	**1.2.9** Improve staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the team-based care model to ensure effective and efficient provision of services (e.g., group visits, medication reconciliation, motivational interviewing, cognitive behavioral therapy and Medication-Assistance Treatment (MAT)).
Not Applicable	**1.2.10** Engage patients using care plans, and self-management education, and through involvement in the design and implementation of this project.
Applicable	**1.2.11** Improve the accuracy and completeness of race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI)

Check, if applicable	Description of Core Components
	data, and use that data to identify and reduce disparities in one or more Primary Care Redesign project metrics by: • Adding granular REAL and SO/GI data to demographic data collection processes and training front-line/registration staff to gather complete and accurate REAL/SO/GI data. • Developing capacity to track and report REAL/SO/GI data, and data field completeness. • Implementing and/or refining processes for ongoing validation of REAL/SO/GI data. • Developing capacity to stratify performance metrics by REAL/SO/GI data and use stratified performance data to identify disparities for targeted interventions. • Developing capacity to plan and implement disparity reduction interventions with input from patients and community stakeholders. • Developing dashboards to share stratified performance measures with front-line staff, providers, and senior leadership.
Not Applicable	**1.2.12** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

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

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]

SCVHHS has begun a five-year Specialty Care transformation effort to improve access, care coordination, quality of care, and population health. Improvement work began as a bottom-up, collaborative effort to address a singular vision: “Provide an experience in specialty care that we would gladly send our families through and that we and our coworkers love and are proud of.” To ensure system-wide readiness for successful transformation, several initiatives have been planned over the next five years, with varied implementation periods to ensure that foundational work can be completed in appropriate steps. These initiatives include:

- Leveraging the EHR system
- Developing and implementing referral guidelines for each specialty
- Engaging providers and building relationships through education and outreach

- Expanding provider networks by leveraging alternative sources of care in the community
- Improving PCP identification and follow up care coordination
- Formalizing Primary Care and Specialty Communication processes
- Triaging referrals for clinical appropriateness
- Measuring supply and demand for Specialty services
- Right-sizing to meet demand for Specialty services
- Staffing referral coordinators for patient communications
- Implementing Telemedicine to improve access
- Employing non-traditional care and patient self-management

SCVHHS is optimizing the EHR to facilitate dialogue between primary and specialty care providers. Referral coordinators will be added to both primary care and specialty care to improve communication with patients and proactively schedule patients for specialty appointments. Electronic referral guidelines will be developed and made available in the EHR for referring providers (including community partners). To sustain changes to the referral process, a provider education campaign will be initiated with a primary focus on the quality and appropriateness of referrals. Efforts are planned to repatriate patients to primary care by improving PCP identification and developing clear communication channels to discharge patients back to their PCP.

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

This project will allow SCVHHS to transform specialty access and improve care by leveraging technology to more efficiently allocate resources and triage based upon clinical need. Primary care providers will be able to use e-Consultations to consult with a specialist and make quick and accurate clinical decisions. The improved communication between the specialist and the referring provider improves continuity of care, enhances collaboration and education, and provides timely follow-up with both the patient and primary care provider.

The EHR will provide easy access to clinical guidelines and create a dialogue that perpetually reinforces those guidelines on every referral. The dialogue engages the PCP in the ongoing care management needs of the patient. These tools will guide providers through the specialty system, and will, over time, increase providers' knowledge base, resulting in accelerated decision-making. The primary care provider is empowered by these tools, which expedite repatriation of patients to their appropriate PCPs for follow-up, and reduce the likelihood those patients will cycle through the system, after having been assessed and treated by a specialist. The utilization of the process will promote better access to specialty providers and provide a platform to sustain improvement.

Patients will have better access to care, and clinical risk associated with delays will be mitigated. Provider time will be used more judiciously in decision making and the provision of care. The result of our project will be cost-effective care that meets the demands of our population.

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

Check, if applicable	Description of Core Components
Applicable	**1.3.1** Develop a specialty care program that is broadly applied to the entire target population.
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.
Applicable	**1.3.8** Ensure that clinical teams engage in team- and evidence-based care.
Applicable	**1.3.9** Increase staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the care model.

Check, if applicable	Description of Core Components
Applicable	**1.3.10** Develop and implement standardized workflows for diversified care delivery strategies (e.g., shared medical visits, ancillary led services, population management, telemedicine services) to expand access and improve cost efficiency.
Not Applicable	**1.3.11** Adopt and follow treatment protocols mutually agreed upon across the delivery system.
Applicable	**1.3.12** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population management activities and care coordination/transitions of care. Ensure that timely, relevant, and actionable data are used to support patient engagement, PCP collaboration, and drive clinical, operational and strategic decisions including continuous quality improvement (QI) activities.
Applicable	**1.3.13** Implement EHR technology that meets MU standards.
Not Applicable	**1.3.14** Patients have care plans and are engaged in their care. Patients with chronic disease (including MH/SUD conditions) managed by specialty care have documented patient-driven, self-management goals reviewed at each visit.
Not Applicable	**1.3.15** Improve medication adherence.
Applicable	**1.3.16** Implement population management strategies for patients in need of preventive services, with chronic conditions, or with recurring long term surveillance needs.
Applicable	**1.3.17** Implement or expand use of telehealth based on DPH/DMPH capacity to address patient and PCP barriers to accessing specialty expertise. Implement a telehealth platform with communication modalities that connect between specialty care and primary care (e.g., eConsult/eReferral).
Not Applicable	**1.3.18** Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**1.3.19** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

Check, if applicable	Description of Core Components
Not Applicable	**1.3.20** Test use of novel performance metrics for redesigned specialty care models.

☒ 1.4 – Patient Safety in the Ambulatory Setting

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]

Many patients have difficulty managing multiple chronic conditions in the ambulatory setting. Diabetes, high blood pressure, cardiovascular disease, and high cholesterol are all chronic conditions. Most of these patients have co-morbidities which necessitate patients to take several medications. Clinicians have to assess whether these drug therapies are both safe and effective. Laboratory tests performed in the ambulatory setting are used to alert and help clinicians make sound evidence-based decisions in the care of their patients. SCVHHS decided to choose this project to improve the care and safe management of these patients on chronic medications.

SCVHHS plans to implement the following discrete interventions by year 2020 to achieve the goals of this project:

1. Formulate interdisciplinary protocols. These protocols will guide the healthcare team including the Clinical Community Pharmacists (CCPs) to proactively review and order laboratory or radiology results relevant to chronic medications being dispensed from SCVHHS pharmacies. If laboratory or radiologic tests are not ordered by the primary care providers for chronic medications, or if the result is out of range, the CCP will liaise with providers to ensure that follow-up testing is ordered appropriately and in a timely manner.

2. Technical prompts will be developed upon ordering/refilling the medications to alert the ordering provider if relevant lab values are not yet resulted or documented in the electronic medical record. Such technical prompts will assist with lab monitoring compliance.

3. Critical values will be monitored daily by the laboratory staff. Any critical values not called to the practitioners will be followed-up with the involved staff. The goal is to call 100% of critical values immediately.

4. Deployment of innovative community pharmacy practitioners or Clinical Community Pharmacists (CCP). CCPs will provide goal-oriented, outcomes-based care at the pharmacy frontlines. These specially-trained pharmacists will work directly with

patients, prescribers, providers, laboratory and radiology to ensure that the medications provided are safe and ensure the best possible patient health outcomes. CCPs will be double-checking if the drugs ordered are safe, if providers ordered the labs, if the patients complied with the orders and picked up their medications. CCPs are pharmacy-based while providers directly see their patients in the clinics.

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

SCVHHS will establish collaborative workflows that promote medication safety, coordinated care, and improved clinical outcomes for our patients. By 2020, CCPs will partner with prescribers, radiology providers and laboratory personnel, to promote medication safety and improve patient outcomes by reviewing, ordering, and tracking results, prior to dispensing chronic medications. The SCVHHS ambulatory patient care team will work proactively with patients to maximize clinical outcomes, ultimately ensuring that patients receive safe, comprehensive, integrated, and timely care in the ambulatory setting.

Calling critical value laboratory test results to providers enables immediate initiation of the necessary care path. Abnormal laboratory values will be sent immediately to the providers' inbox in the Electronic Health Record (EHR) with abnormal flag alerts. This will enable providers to adjust patient care, if necessary.

Providers will have support from the interdisciplinary team making them more empowered to make evidence-based decisions. With empowered and strong providers and interdisciplinary team, patients will feel more engaged, more trusting, and healthcare outcomes will be improved.

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.
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.
Applicable	**1.4.3** Develop a standardized workflow so that:

Check, if applicable	Description of Core Components
	• 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.
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.
Not Applicable	**1.4.5** Implement technology-enabled data systems to support the improvement and performance feedback system as well as engage patients and support care teams with patient identification, pre-visit planning, point of care delivery, and population/panel management activities.

Please complete the summary chart:

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

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

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

☒ 2.1 – Improved Perinatal Care (required for DPHs)

Summarize your approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words]

This project's design aligns with SCVHHS's strategic initiative to form a Women's and Children's service line that improves efficiency, patient experience and quality across the continuum of care for pregnant women. This project design is modeled after that service line structure with an interdisciplinary approach to change and transformation. Much like the transformational work in the service line, the PRIME perinatal team participants include clinicians from both ambulatory and inpatient, as well as representatives from quality, finance and IT departments. Inclusion of a cross section of stakeholders and clinicians involved in care supports maximization of effort.

To implement, we will employ numerous safe and effective evidence-based practices to help guide maternal care decisions that facilitate optimal outcomes, which ultimately support maternal and neonatal safety. These include validated methods related to OB hemorrhage, the Baby Friendly hospital initiative and maternal care decisions that support physiologic birth. Validated method, i.e., the CMQCC toolkit for OB Hemorrhage has already been implemented in this organizations' Labor and Delivery department. As part of the PRIME initiative, the OB Hemorrhage toolkit will be developed in the post-partum unit as well. Additionally, the toolkit will be reviewed to identify any best practices for the prenatal patients who fall under the high risk category for potential OB hemorrhage.

SCVMC is in phase three of the Baby Friendly Hospital Initiative's four phases. Thus the Baby Friendly's 10 steps are currently being disseminated throughout the 7 primary care clinics, labor and delivery, post-partum and neonatal ICU departments. Through the PRIME efforts, the BF journey will continue through site visit and verification. Since Baby Friendly's efforts support both breastfeeding and maternal/infant bonding, all maternity patients are included in this component.

Over the last several years, SCVMC's obstetrical service has supported physiological birth practices by being an early adopter of not performing elective inductions or Cesarean sections before 39 weeks gestation. Thus, SCVMC has well documented safe patient outcomes in the CMQCC database. As a clinical leader in this domain, SCVMC plans to implement best practices from the newly released CMQCC's toolkit on Promoting Vaginal Births and Reducing Primary Cesarean Sections in all SCVMC's prenatal patients including both low and high risk mothers as appropriate. Furthermore, education and partnership with the federally qualified clinics who also refer patients for delivery to SCVMC will be part of the initiative so that all mothers

delivering at SCVMC are evaluated using the toolkit's best practice that reduce morbidity related to early induction or cesarean sections.

Although a required domain, addressing perinatal care outcomes is essential in public hospitals redesign. Maternal care in California is the single greatest financial burden of public dollars, and maternal outcomes do not necessarily reflect this resource utilization. Although maternal care has improved over the last ten years, in relation to morbidity, mortality and racial disparities in the state and Santa Clara County, much work is left to continue this positive trend. As the third largest birth center in the County, SCVHHS has great capacity to impact the maternal health in the region and serve as a clinical leader role model for the best practices of maternal/newborn care.

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

SCVHHS has approximately 16% of the birth volume in the County; however, it disproportionately has the highest volume of high risk pregnancies to mothers with gestational diabetes, eclampsia and obesity, according to data from the California Maternal Quality Care Collaborative (CMQCC). Although this organization cares for the mothers at greatest risk for birth complications, SCVHHS's overall cesarean section rate is low, considering the volume of high risk patients. This project enables the organization to both maintain these quality outcomes and to further the improvement of care by focusing efforts and resources on additional best practices related to maternal and infant outcomes.

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

Check, if applicable	Description of Core Components
Applicable	**2.1.1** DPHs/DMPHs engagement in best practice learning collaborative to decrease maternal morbidity and mortality related to obstetrical hemorrhage (CMQCC/PSF/HQI combined effort).
Applicable	**2.1.2** Achieve baby-friendly hospital designation through supporting exclusive breastfeeding prenatally, after delivery, and for 6 months after delivery and using lactation consultants after delivery.
Applicable	**2.1.3** Encourage best practice and facilitate provider education to improve cesarean section rates, and decrease inequities among cesarean section rates. Participate, as appropriate, in statewide QI initiatives for first-birth low-risk cesarean births.
Applicable	**2.1.4** Coordinate care for women in the post-partum period with co-morbid conditions including diabetes and hypertension.

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

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]

At SCVHHS, the unplanned readmission rate among high-risk patients is directly related to issues with housing needs, availability of cognitive behavioral skilled nursing facilities, and psychosocial issues. However, housing is being addressed by the Whole Person Care (WPC) and Global Payment Plan (GPP) model, which will specifically address patients with psychosocial and economic factors, including the homeless who also fall under PRIME population.

SCVHHS will introduce evidence-based and patient-centric interventions, based on available outcome data and focus on patient self-management, patient and family engagement, safe transitions across the care continuum, decrease avoidable utilization of acute care resources, reduce disparities in health and health care, and reduce hospital readmissions and frequent emergency room (ER) visits. The collection of programs such as Project RED, BOOST and ERIC Coleman Care Transition models, is an early compilation of promising efforts to meet this goal.

Discrete interventions include:

- Leveraging our EHR to meet our data needs and objectives through data sharing, standardization, transition of records, improved patient access (through 'MyHealthonline'), and building relationships with other acute hospitals and community partners.
- Implementing LACE (Length of stay, Acuity, Co-morbidities, ED visits Assessment tool to identify high risk patients and target interventions.
- Updating the patient admission assessment tool in conjunction with the Institute for Health Care Improvement (IHI) Observation Guide: Observing Discharge Processes, to meet the needs of patients and their families at the time of discharge.
- Assessing pre-admission and ED care coordination; gaps identified will be addressed, including staffing needs.
- Enhancing patient satisfaction initiatives currently utilized, such as CICare (Connect Introduce Communicate Ask Respond Exit).
- Transitions of Care (TOC) Access Program schedules outpatient follow-up with primary care providers (PCP) prior to discharge from hospital.

- Ambulatory Transitions of Care (AMB-TOC) program is a telephonic call to HRHC patients within 72 hours of hospital discharge.
- TOC-Public Health Nurse Project include Case Managers (transition coaches) or physicians who assign the top 1.5 % of HRHC patients to PCPs, and refer them to appropriate services post hospital discharge.
- A multidisplinary planning team formed is tasked with selecting the most appropriate Care Coordination Model, educate and engage front line staff, senior leadership and representatives from our community partners, obtain ongoing feedback and implement a process to sustain best practices.

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

PRIME project 2.2, in collaboration with other Medi-Cal 20/20 initiatives, will improve care, promote quality of life, and reduce excessive spending on High-Risk or High-Cost (HRHC) patient population, thereby supporting the IHI Triple Aim.
HRHC patients will be closely monitored with care coordinated by social service agencies which will aim to rehabilitate this population and meet their immediate housing and other needs.

This project will allow SCVHHS to identify areas for improvement in care transition and create opportunities to replace fragmented systems of care with more fully integrated care coordination infrastructure. It will allow the health system to proactively respond to reach patient's needs in an appropriate , timely and holistic manner, across the continuum of care. SCVHHS has formed a core team, which aligns other PRIME projects, to identify shared linkages with other services, which minimally include the welfare, mental health, substance abuse, public health nursing agencies. Opportunities will be sought to collaborate with other social services and community-based organizations, required to meet HRHC patient needs in the county. These may include direct and indirect services, including: 1) transportation for follow-up appointments, 2) access to care meals, 3) provision of medical equipment, and 4) outreach. Through PRIME, opportunities will be available to advance innovation in both the acute and the post-acute setting. SCVHHS anticipates implementing additional programs, based on patient and community feedback over the course of the PRIME waiver, to provide additional value for this patient population.

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

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

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

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]

There is an overwhelming body of evidence to substantiate that patients with multiple physical health, behavioral health, and social needs are the highest consumers of health care services and costs. Despite this, they often experience some of the worst health outcomes, therefore we strongly support this project as foundational to the system-wide transformation of care for our patients.

A multidisciplinary team will be responsible for designing the complex care management model and will work in close conjunction with Ambulatory Care Primary Care redesign team and the Care Transitions team, so that the model is embedded in and synergistic to a larger overall care model. This structure will ensure all projects reinforce the tenants of Patient Centered Medical Home.

The design team will utilize principles for an embedded care manager model and base some of the design on the successful results from the Medicare Coordinated Care Demonstration projects which included the following:

- In person contact with patients
- Timely information on hospital and emergency room admissions
- Close coordination between the care manager and PCP
- Coordination of care transitions and close follow-up
- Patient self-management support and activation, including medication education
- Social support

Although many of these elements will be incorporated in the design, our system will foster continual innovation for the design by ensuring both team and patient feedback is consistently incorporated through a quality improvement methodology.

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

It is the vision of SCVHHS to provide a seamless, integrated, and patient-centric system of care, which addresses all patient needs in a holistic manner. The goal is to replace fragmented systems of care with a fully-integrated care coordination infrastructure, in which all needs of the patient will be addressed, not only in a single location but, when possible, in a single visit. For patients with multiple co-morbidities, including behavioral health, substance abuse and social issues, the goal is to coordinate care that optimally addresses the patient's needs during the primary

care visit.

Through collaboration with other project teams working on Medi-Cal 2020 initiatives, including primary and specialty care projects within PRIME and high-utilizers of care within Whole Person Care, SCVHHS seeks to share resources and redesign infrastructure in an effort to enhance care coordination across multiple services and platforms. Ultimately, this will increase opportunities to streamline care for patients with complex needs, optimize ways in which the patient plays an active role in managing and maintaining optimal health, and intervene appropriately to ensure no reduction in baseline health occurs.

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

Check, if applicable	Description of Core Components
Not Applicable	**2.3.1** Develop a complex care management program at one site or with one defined cohort, or expand an existing program from a pilot site to all sites or to additional high-risk groups and demonstrate engagement of patients in the design and implementation of the project.
Not Applicable	**2.3.2** Utilize at least one nationally recognized complex care management program methodology.
Applicable	**2.3.3** Identify target population(s) and develop program inclusion criteria based on quantitative and qualitative data (e.g., acute care utilization, lack of primary care utilization, number of high-risk medical mental or SUD conditions, polypharmacy, primary care input, functional status, patient activation, social support or other factors). Include patient factors associated with a higher probability of being impacted by complex care management.
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.

Check, if applicable	Description of Core Components
Applicable	**2.3.7** Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets.
Applicable	**2.3.8** Implement evidence-based practice guidelines to address risk factor reduction (smoking cessation/immunization/substance abuse identification and referral to treatment/depression and other behavioral health screening, etc.) as well as to ensure appropriate management of chronic diseases: • Use standardized patient assessment and evaluation tools (may be developed locally, or adopted/adapted from nationally recognized sources). • Use educational materials that are consistent with cultural, linguistic and health literacy needs of the target population.
Not Applicable	**2.3.9** Ensure systems and culturally appropriate team members (e.g. community health worker, health navigator or promotora) are in place to support system navigation and provide patient linkage to appropriate physical health, mental health, SUD and social services. Ensure follow-up and retention in care to those services, which are under DPH/DMPH authority, and promote adherence to medications.
Not Applicable	**2.3.10** Implement technology-enabled data systems to support patients and care teams throughout the care management program including patient identification, pre-visit planning, point-of-care delivery, care plan development and population/panel management activities.
Not Applicable	**2.3.11** Implement a data-driven system for rapid cycle improvement and performance feedback to address quality and safety of patient care, which includes patients, front line staff and senior leadership.

☒ 2.4 – Integrated Health Home for Foster Children

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]

In 2014, the rate of children in foster care in Santa Clara County increased to 2.6 per 1,000. Most of these children are in foster care because of physical abuse or neglect, and are more likely to suffer from depression, attempt suicide, commit

crimes, abuse alcohol and drugs, and demonstrate learning and behavioral difficulties in school.
SCVHHS is committed to making a positive impact on these children through early identification of physical and behavioral health care needs and interventions. Through early intervention, health care providers can positively inf luen ce ch ildren ’s health and development, and can also improve their readiness to learn at school and decrease the risk for many adult diseases.

Under the existing model, SCVHHS operates a clinic dedicated to the care of foster children – The SPARK (Supporting, Protecting, and Respecting Kids) Clinic. Under the proposed project, the SPARK Clinic will be integrated with the new Valley Health Center Downtown San Jose (VHC Downtown), a federally qualified health center (FQHC). VHC Downtown will support a fully realized patient centered health home model that will include direct access to medical, behavioral, and legal services. Utilizing the established model of care inherent in an FQHC, foster children will receive enhanced services that will supplement the efforts of established points of contact that include the Department of Behavioral Health, Children and Family Services, and Social Services Agency. The SPARK clinic will provide a team of dedicated physicians, nurse practitioners, case managers, and support staff who recognize the unique needs of this especially at-risk population. The mental, behavioral, and social needs of the foster youth will be provided for by direct access to health center based psychiatrists, social workers, and psychologists. The health center will also host an office of the Medical Legal Partnership (MLP). A HRSA recognized program, MLP will provide access to no-cost legal services – provided by an attorney – that will assist with the legal needs of the foster child.

Local organizations that include Kinship and the Foster and Adoptive Parent Association will be key partners in developing and implementing the project. Utilizing existing community and County partnerships that exist across the County foster care spectrum, a program will be developed to not only augment the current health delivery system, but to explore new and supportive efforts that would include educational programs for children and their foster families, group classes and sessions, parenting programs for biological parents, and support groups dedicated to the success of foster children and their families

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

This project will demonstrate a measurable improvement in care to the foster child community by providing enhanced access to services in a “one stop” environment. Traditionally, access to services is fragmented by services provided in different locations, different county departments, and limitations to access based upon diagnosis and funding streams. With integration into the FQHC model, many of these barriers to care are eliminated. We would expect to see increased compliance to not

only with health care treatment plans, but also to utilization of support services as access is not limited by the need to travel to multiple locations or having to transact with multiple entities.

The FQHC model will also provide additional support services that include on-site access to:

- financial counselors (to assist with insurance challenges),
- on-site pharmacy (providing timely access to medications as well as pharmacist assisted medication management)
- specialized programs such as the Pediatric Health Lifestyles Clinic (addressing obesity and other lifestyle challenges)
- physician directed substance abuse diversion programs to supplement the efforts of the Medi-cal drug and alcohol treatment programs
- intensive case management to ensure care coordination and continuity

Through the efforts of this project, SCVHHS endeavors to ultimately remove barriers and increase access to care, which will result in increased compliance and adherence to the required project metrics and their measurables.

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

Check, if applicable	Description of Core Components
Applicable	**2.4.1** Healthcare systems receive support in the ongoing management and treatment of foster children: Demonstrate engagement of patients and families in the design and implementation of this project.
Applicable	**2.4.2** Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration).
Applicable	**2.4.3** Multi-therapeutic care team will: • Identify patient risk factors using a combination of qualitative and quantitative information. • Complete a patient needs assessment using a standardized questionnaire. • Collaborate on evidence-based standards of care including medication management, care coordination and care engagement process. • Implement multi-disciplinary case conferences/consults on patients with complex needs. • Ensure the development of a single Treatment Plan that includes the patient's behavioral health issues, medical issues, substance abuse and social needs: o Use of individual and group peer support.

Check, if applicable	Description of Core Components
	• Develop processes for maintaining care coordination and "system continuity" for foster youth who have one or more changes in their foster home. • Ensure that the Treatment Plan is maintained in a single shared EHR/clinical record that is accessible across the treatment team to ensure coordination of care planning. • Assess and provide care for all routine pediatric issues with a specific focus on: o Mental health/toxic stress o Obesity o Chronic disease management o Medication/care plan adherence which are vulnerable when kids transition care givers frequently o Substance abuse issues o Developmental assessment, identification and treatment
Applicable	**2.4.4** Implement technology-enabled data systems to support pre-visit planning, point-of-care delivery, population/panel management activities and care coordination. Timely, relevant and actionable data is used to support patient engagement, and drive clinical, operational and strategic decisions including continuous QI activities.
Applicable	**2.4.5** Provide linkages to needed services that at a minimum includes child welfare agency, mental health, substance abuse and public health nursing as well as any other social services that are necessary to meet patient needs in the community.
Applicable	**2.4.6** Develop liaisons/linkage with school systems.
Applicable	**2.4.7** Provide timely access to eligibility and enrollment services as part of the health home services.
Applicable	**2.4.8** Evidence-based practice guidelines will be implemented to address risk factor reduction (e.g., immunization, smoking cessation, behavioral health screening) as well as to ensure appropriate management of chronic diseases (e.g., asthma, diabetes). Assessment of social service needs will be integral to these activities. Educational materials will be utilized that are consistent with cultural and linguistic needs of the population.
Applicable	**2.4.9** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement, that includes patients, front line staff, and senior leadership.

Please complete the summary chart:

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

Section 4.3 – Domain 3: Resource Utilization Efficiency

☒ 3.3 – Resource Stewardship: Therapies Involving High Cost Pharmaceuticals

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]

Specialty medications are the fastest growing segment of the prescription drug market. Specialty medications treat complex, chronic or life-threatening conditions, are costly and require special handling, storage, administration, monitoring, and significant patient education and support. With hundreds of specialty medications on the market and thousands more in the pharmaceutical pipeline, SCVHHS has realized the need to enter the specialty pharmacy space in order to provide cost-effective, coordinated, high-quality care for patients taking high cost pharmaceuticals.

Developing a Specialty Pharmacy will provide an opportunity for business, financial, and clinical growth. The Specialty Pharmacy Service will improve patients' access to specialty medications, improve coordination of care, support providers and patients with insurance billing and processing, including prior authorization facilitation. Specialty pharmacy services will encourage medication safety and adherence, and promote the establishment of high-level clinical pharmacists in the ambulatory setting.

Accreditation is offered by third party independent organizations, such as The Joint Commission. Accreditation standards are rigorous, patient-centered, and focus on performance improvement, quality of care, and patient satisfaction. Accreditation also provides distinction. Payers often contract with accredited specialty pharmacies that promote adherence and treatment success, which lead to cost savings. Over the next five years, SCVHHS will establish a Specialty Pharmacy Service and obtain accreditation. Based on patient needs, initial focus will be placed on Hepatitis C specialty medications, and expand to rheumatoid arthritis, multiple sclerosis, oncology, HIV and other disease states by 2020.

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

PRIME 3.3 project has a target population defined as the PRIME eligible population and individuals with any acute care utilization at SCVHHS during the measurement period. SCVHHS's Specialty Pharmacy Service will collaborate with prescribers to curtail overuse, misuse, and inappropriate or underuse of high-cost specialty

pharmaceuticals. A protocol will be established to find low-cost alternatives and, when unavailable, provide guidance to clinicians for evidence-based and appropriate use of high-cost pharmaceuticals. Patients will receive comprehensive, integrated care within SCVHHS.

2016 Story: Patient comes to SCVHHS to see the physician, who writes two prescriptions – "A" and "B." The patient normally picks up all medications at SCVHHS pharmacy. Per the health plan, medication B cannot be filled by SCVHHS pharmacy, since it is a high-cost specialty medication. Instead, the patient must go outside SCVHHS to a specialty pharmacy to fill medication B. The patient receives prescription A from SCVHHS pharmacy and prescription B from an outside specialty pharmacy. The physician can see the prescription fill history for prescription A at SCVHHS pharmacy but cannot see the prescription status for prescription B, since the pharmacy is outside SCVHHS. The patient experiences uncoordinated care and has an unsatisfying experience.

2020 Story: Patient comes to SCVHHS to see the physician, who writes two prescriptions – "A" and "B." The patient normally picks up all medications at SCVHHS pharmacy. Per the health plan, all medications can be filled by SCVHHS pharmacy, since SCVHHS is a Specialty Pharmacy. The patient receives prescriptions A and B from SCVHHS pharmacy. The physician can see the prescription fill history for both prescriptions A and B at SCVHHS pharmacy. The patient experiences coordinated, integrated care and has an excellent experience.

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

Check, if applicable	Description of Core Components
Applicable	**3.3.1** Implement or expand a high-cost pharmaceuticals management program.
Applicable	**3.3.2** Implement a multidisciplinary pharmaceuticals stewardship team.
Not Applicable	**3.3.3** Develop a data analytics process to identify the participating PRIME entity highest cost pharmaceuticals (high-cost medications or moderate-cost meds with high prescribing volume). Identify high-cost medications whose efficacy is significantly greater than available lower cost medications. • Using purchase price data, identify the top 20 medications and medication classes, focusing on the following: Analgesics, Anesthetics, Anticoagulants, Anti-Neoplastics, Diabetes, Hepatitis C, Immunoglobulins, Mental Health (Anti-Depressants/Sedatives/ Anti-Psychotics), Respiratory (COPD/Asthma), Rheumatoid Arthritis. o Exclude Anti-Infectives and Blood Products (addressed in separate PRIME Projects).
Not Applicable	**3.3.4** Develop processes for evaluating impact of high-cost, high-efficacy drugs, particularly drugs to treat conditions (e.g., HCV) or to address circumstances (e.g., oral anticoagulants for patients without transportation for blood checks) more prevalent in safety net populations: • Consider criteria that include ability of identified medications to improve patient health, improve patient function and reduce use of health care services.
Applicable	**3.3.5** Develop processes to impact prescribing by providers by establishing standards of care regarding prescribing of high cost pharmaceuticals, including: • Use of decision support/CPOE, evidence-based guidelines and medical criteria to support established standards. • Develop processes to improve the appropriate setting for medication delivery including, transitioning pharmaceutical treatment to the outpatient setting wherever possible. • Promote standards for generic prescribing. • Promote standards for utilizing therapeutic interchange.
Not Applicable	**3.3.6** Improve the process for proper billing of medications, through clinician education and decision support processes.

Check, if applicable	Description of Core Components
Not Applicable	**3.3.7** Develop formulary alignment with local health plans.
Not Applicable	**3.3.8** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership rapid cycle improvement using standard process improvement methodology.
Applicable	**3.3.9** Develop organization-wide provider level dashboards to track prescribing patterns for targeted high cost pharmaceuticals. Dashboard to include comparisons to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.
Not Applicable	**3.3.10** Develop processes for working with providers with prescribing patterns outside established standards, to identify and reduce barriers to meeting prescribing standards: • Develop guidelines and provide staff training on methods for engaging patients in shared decision making for developing treatment plans within the context of the established standards.
Not Applicable	**3.3.11** Maximize access to 340b pricing: • Share templates for contracting with external pharmacies. To improve program integrity, share tools for monitoring of 340b contract compliance.

Please complete the summary chart:

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

Section 5: Project Metrics and Reporting Requirements

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

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

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

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

Section 6: Data Integrity

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

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

Section 7: Learning Collaborative Participation

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

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

Section 8: Program Incentive Payment Amount

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

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

- DY 11 $ 119,883,400.00
- DY 12 $ 119,883,400.00
- DY 13 $ 119,883,400.00
- DY 14 $ 107,895,060.00
- DY 15 $ 91,710,801.00

Total 5-year prime plan incentive amount: $ 559,256,061.00

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.