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

UC Davis Medical Center

Health Care System Designation(DPH or DMPH)

DPH

Section 2: Organizational and Community Landscape

The purpose of this section is to provide DHCS with an understanding of the demographic makeup of the community the applicant serves, the target population that will benefit from the PRIME activities, and any other relevant information that will help inform the state's review of this Plan.

2.1 Community Background. *[No more than 400 words]*
Drawing on available data (e.g., DHCS, Office of Statewide Health Planning and Development, U.S. Census Bureau), summarize the health care needs and disparities that affect the health of your local community.

In 1994, SB697 was passed by the California legislature requiring hospitals to conduct a community health needs assessment (CHNA) every three years to maintain their tax-exempt status. In the 2013 CHNA prepared for UC Davis Medical Center, 15 Communities of Concern, touching more than 400,000 Sacramento County residents, were identified that had a high burden of disease and health statistics that exceeded the benchmarks set for Healthy People 2020.[1] Seven of these communities had higher percentages of residents over age 65 living in poverty compared to the national benchmark, and for 13 of the 15 Communities of Concern the percentage of families with children living in poverty was higher than the national average of 15.1%. In ZIP code 95824, the proportion of residents without a high school diploma was 43.5%, which is more than two times the state benchmark and three times the national benchmark. Additionally, 93.9% of the residents in the 95814 ZIP code rent rather than own their homes.

ZIP code 95814 is striking for many of its health statistics. ZIP code 95814 in Sacramento County has the highest mortality rate, emergency department (ED) visit rate, and hospitalization rate due to diabetes in the area at 4.0 per 100,000, 573.6 per 100,000, and 425.5 per 100,000, respectively. The rate for mental health-related ED visits in ZIP code 95814 was seven times the state benchmark and four times the county benchmark. The rate of substance abuse-related ED visits was five times the state rate. One key informant interviewed in the CHNA noted, "A lot of mental health services that were available to our clients are gone now."[1]

Eight of the 15 Communities of Concern have been designated as health professional shortage areas, including ZIP code 95814. Here there is a lack of access to primary, secondary, and preventive care. Additionally, patients with Medi-Cal coverage frequently have difficulty finding care because coverage is limited or clinics are not open to new patients. One respondent from a CHNA focus group noted, "I have been enrolled [through Medi-Cal] with doctors I've never seen, but I have a card that says I am their patient. And they tell me 'we have no space for you…'"[1] This places additional pressures on local hospitals, like UC Davis Medical Center, to serve as the

community safety net. One key informant noted, "…these patients wait until their medical problems get out of control and then have no choice but to go to the emergency room." [1]

In conclusion, the top three areas health priorities from the 2013 CHNA include lack of access to: 1) primary health care services, 2) mental health treatment and prevention services, and 3) coordinated care. Additionally, these communities have significant barriers to active lifestyles including high rates of crime, unsafe traffic patterns for cyclists and pedestrians, and high concentrations of fast food outlets and convenience stores—all of which contribute to stress, social isolation, and obesity.

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

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

UC Davis Medical Center serves the racially and ethnically diverse population of Sacramento County, which is home to nearly 1.42 million Californians according to 2010 US census data.[2] Sacramento County has five major cities (ie, Citrus Heights, Elk Grove, Folsom, Rancho Cordova, and Sacramento), the largest of which is Sacramento, home to 31.5% of the county's residents.

Income. The average per capita income in Sacramento County is $27,071 (in 2014 dollars), and the median household income is $55,615 (in 2014 dollars). Additionally, 18.1% live at or below the poverty line.[2]

Race/Ethnicity and Language. The population of Sacramento County is 57.5% white, 21.6% Hispanic, 14.3% Asian, 10.4% African American, 1.0% Native American/ Alaska Native, and 1.0% Native Hawaiian/Pacific Islander. While the primary language is English, more than 31.3% of the population reports speaking a language other than English at home.[2]

Age. In the 2010 census, the median age for Sacramento County was 34. The age breakdown is as follows:

- 0-18 years (25.6%)
- 19-64 years (63.2%)
- 65 and over (11.2%)[2]

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.

UC Davis Medical Center operates the only level 1 trauma center for both adult and pediatric emergencies in inland Northern California. The range of services provided includes acute inpatient, outpatient, and emergency care as well as diagnostic services and outpatient psychiatric services. Of the Medical Center's 627 beds, 114 are designated adult ICU, 73 pediatric ICU, 400 adult acute care, and 40 pediatric acute care. The UC Davis Medical Center has received recognition from The Joint Commission for programs in stroke and ventricular assisted devices. Currently, the UC Davis Children's Hospital is seeking children's surgery verification from the American College of Surgeons.

UC Davis Medical Center provides services to the community through the hospital as well as the Primary Care Network (PCN), which includes 15 community primary care clinics. Additionally, three hospital-based clinics in family and community medicine, internal medicine, and pediatrics provide training opportunities for residents and are located on the medical center campus proper. In 2014, these 18 primary care clinics and their 141 associated physician providers received recognition from the National Committee for Quality Assurance (NCQA) as a Patient-Centered Medical Home (PCMH). Medical services are provided 24/7 in the ED, and limited urgent care coverage is provided at select PCN clinics after hours and on weekends.

In fiscal year 2014, UC Davis Medical Center's payer mix volume was: 33% Medicare, 35% Medi-Cal, 23% private insurance, and 6% other indigent care. UC Davis Medical Center had 33,799 acute inpatient discharges and 1,043,548 ambulatory care visits (ie, including ED visits). The average length of stay for acute care was 5.2 days. Hospital beds had an 83% occupancy rate, and the percentage of staffed beds to licensed beds was 78%.[3]

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.

The UC Davis Medical Center has developed tools for population health reporting required for PCMH recognition and participation in the 2010-2015 Delivery System Reform Incentive Program (DSRIP). Using data abstracted from the Epic electronic health record (EHR), the Clinical Registries Team provides monthly tracking of health statistics that are important to PCMH initiatives such as pediatric obesity, screening mammograms, influenza and HPV vaccinations, blood pressure control, and tobacco cessation counseling for an ambulatory population of more than 145,000 patients. Patients accrue to the population based on whether they have had an office visit at a

PCMH clinic in a rolling 18-month period. PCMH statistics are shared with clinic medical directors on a monthly basis.

UC Davis Medical Center's PRIME reporting will be completed by the Metrics Development Team, comprised of programmer analysts and business analysts, working with Clinical and Operational Subject Matter Experts (SMEs) from the various clinical areas engaged in PRIME. Each metric has been assigned one or more of the Clinical and Operational SMEs. The programmer analysts will write reports based on the measure specifications with guidance from the SMEs; the analysts will build a custom database for reporting, visualization, and auditing the data. The SMEs will identify and verify the integrity of the data being extracted for reporting.

The anticipated limitations and barriers are being able to report EHR data from structured fields and having sufficient personnel resources to address manual data collection. Our strategy to address the limitations is to identify early on the metrics that will require manual collection and to collaborate with the SMEs in: 1) outlining a manual collection process and 2) beginning the design of workflows and EHR enhancement specifications to enable data collection and reporting from the EHR. Early identification of manual metrics will allow for resource planning and piloting the collection of data from unstructured fields.

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.*

   Like many academic medical centers, UC Davis Medical Center has operated in a fee-for-service market based on a small proportion of patients generating funds to support clinical, teaching, and research activity. These funds have traditionally come from tertiary/quaternary services including organ transplantation, procedural specialization, and cancer treatment. Although reimbursement systems are slow to reward efforts to improve the health of populations, we hope that incentive programs such as PRIME, which follow in the footsteps of the Centers for Medicaid and Medicare Services' Meaningful Use and the Integrated Healthcare Association's Pay for Performance, spur infrastructure enhancements that allow UC Davis Medical Center to:

   1. Adapt to a competitive value-driven payer market;
   2. Improve measurement and surveillance of outcomes in patient subgroups; and
   3. Engage patients in shared decision making and clinical system redesign.

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.*

Despite its success in a fee-for-service environment, the UC Davis Medical Center must focus on adapting to new payment paradigms, which will require a greater investment in primary care and preventive health infrastructure and ongoing monitoring of costs and quality in our delivery of inpatient care. Participation in PRIME should help us be successful in:

1. Soliciting patient and family attitudes, preferences, and beliefs through the improvement process;
2. Expanding technology to decompress primary and specialty care; and
3. Improving communication and coordination of care between patients, providers, and care teams in inpatient and ambulatory settings.

Additionally, UC Davis Medical Center is positioned to collaborate with community providers through emerging partnerships with skilled nursing, improved relations with Sacramento County's public health system, and better communication between Medi-Cal GMC patients admitted to the medical center and the health plans responsible for their care.

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;*

Our ambulatory care quality improvement goals are influenced by the requirements of health plans, government-sponsored incentive programs, and accountable care organizations. Integration of mental health and primary care, care coordination, specialty access, safety, and clinical improvement are common themes in these program as well as PRIME. Management of non-malignant pain addresses safety concerns and dovetails with a new UC Davis Medical Center policy on chronic opioid prescribing and monitoring that centers on patient evaluation and risk stratification. High-cost imaging in PRIME has been selected for its alignment with Choosing Wisely improvement goals, which emphasize clinical efficacy, cost reduction, and decision support. Lastly, implementation of clinical practice guidelines is reinforced with PRIME's Million Hearts, which highlights blood pressure reduction and smoking cessation as key steps in mitigating patients' risk of stroke and heart disease.

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*

Several of our PRIME projects and technical experts will create bridges between delivery system redesign and high-risk populations. Our technical expert on non-malignant pain management is a psychiatrist recognized for his experience in "cross disciplinary training" at the interface of primary care medicine, chronic pain management, and psychiatry. A second technical expert in psychiatry has collaborated with primary care providers to develop the mental health component of the Care Coordination Program. The Care Coordination Program is being explored for expansion as part of the UC Davis Medical Center's Transitions of Care initiative. With PRIME, we are looking forward to integrating behavioral health with complex care management of high-risk populations to ensure mental health is addressed among other discharge needs after an acute care episode.

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.*

In the next five years, we hope to develop systems of care that capitalize on technology. UC Davis Medical Center has one of the most mature and successful telemedicine programs in the United States. Telemedicine in PRIME may be operationalized not only through patients' texting or sending digital images to their primary care physicians but also through clinical visits conducted between specialists and patients over video conference, thereby improving operational efficiency, patient satisfaction, and continuity of care.

Beyond technology, we hope to build collaborative care delivery models that meet the diverse needs of Sacramento County and fill the care gaps related to poor access, coordination, and integration of mental and physical health. We hope to achieve this through better patient and family engagement in process improvement as well as through our evolving population health analytics so that providers and care teams can improve patient outcomes at the point of care using data that are meaningful, relevant, and timely.

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

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

As mentioned earlier, the UC Davis Medical Center's 2013 CHNA acknowledges a significant need for improved mental health resources in the 15 designated Communities of Concern of Sacramento County. Many patients with mental health

needs present in local EDs in crisis with little hope of receiving longitudinal care in the community when they are discharged. As one CHNA key informant put it, "…the ability for these [mental health] patients to get any kind of help or follow up is woefully lacking…and so we end up having extended long periods of stay… but no place for them to go."[1]

Three projects in the UC Davis Medical Center PRIME portfolio specifically address mental health through integration with primary care (Project 1.1), care planning for high-risk patients with complex medical needs (Project 2.3), and the management of chronic non-malignant pain (Project 2.6). These projects will be initiated in ambulatory settings with the goal of creating a supportive care environment in which patient risks, cultural norms, and values inform the clinical decisions of an interprofessional team. Additionally, clinics and staff will become resources for eliciting patient needs and readiness for change through techniques such as motivational interviewing that encourage patients to self-reflect on the impacts of positive behaviors. Lastly, clinical policies will be developed that ensure patient safety through greater awareness and responsiveness to changes in patient status, whether it's expressed as signs of suicidal ideation or growing dependence on narcotics.

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).

Dr. Gregory Maynard, Chief Quality Officer, is leading the efforts in implementing a quality improvement strategy for the medical center. The QI and PRIME priorities are organized and driven using an established committee structure and a concept named the "Value Construct". The committee structure is the primary forum for advancing the QI strategy and receiving feedback, and includes the Quality and Safety Operations Committee (QSOC) for inpatient settings and the Primary Care Network (PCN) quality committee for outpatient settings. Furthermore, there is a PRIME committee structure detailed below which includes Project Champions, who are most closely aligned to the work being done with front line staff, to identify issues in processes and performance and use PRIME committee structure for appropriate escalation and resolution. The concept of the "Value Construct" at UC Davis Medical Center has been used to reinforce the message of the triple aim – improved patient experience, better outcomes, reduced cost – in the improvement efforts initiated in our inpatient and ambulatory settings. This concept is foundational to PRIME by linking quality and safety activities to improved outcomes. Additionally, PRIME acts as a stimulus for improving our EHR reporting

infrastructure based on an affiliate model. This model creates EHR builds and enhancements guided by experts in clinical workflows. It also uses IT consultants to develop systems for producing and reporting actionable data from those clinical workflows. The affiliate model is critical to establishing common outcome and process measures and helps disseminate data to the point of care throughout the clinical enterprise.

Another aspect of the infrastructure established for PRIME is the development of the PRIME Oversight and Executive committees. The Oversight Committee meets monthly and is a convening of all project champions. The meeting is the venue for champions' providing feedback about challenges and barriers affecting project success; monitoring progress toward project goals; summarizing resource needs for the Executive Committee; and discussing cross-cutting issues regarding data collection and reporting that potentially impact all projects. Concerns that cannot be resolved at the Oversight Committee level are escalated to the PRIME Executive Committee, which also meets monthly and can authorize resources, prioritize data infrastructure needs, and monitor milestone achievements alongside anticipated revenue from earned incentives.

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.

UC Davis Medical Center collaborates closely with the County of Sacramento to develop innovative programs to help manage the great influx of patients suffering from mental disorders who are seeking treatment in EDs. New mobile crisis teams have been developed that include county mental health providers who accompany sheriff deputies and police officers to divert patients to the psychiatric crisis stabilization unit rather than the ED. The psychiatrist with whom they coordinate these referrals is a UC Davis Medical Center faculty member. Currently in development is an Urgent Care Clinic that will be staffed by UC Davis psychiatrists, residents, and medical students to serve as an alternative to more intensive services, such as the crisis stabilization unit. Finally, triage and peer navigators are now assigned to the UC Davis Medical Center ED in order to more rapidly transfer patients suffering from mental disorders to community programs. The triage and peer navigators work closely with the UC Davis ED faculty and staff.

UC Davis Medical Center's connection to these resources helps patients in mental health crisis – a significant community concern for Sacramento County. One goal of PRIME will be to strengthen behavioral health in primary care so that patients don't reach the point of crisis. To that end, our primary care clinics participating in PRIME will involve patients and their families in system redesign. In the last two

years, patient focus groups have been organized in our Primary Care Network and primary care hospital-based clinics to evaluate clinical procedures and operations to maximize what patients value – access, coordinated care, and communication. Additionally, tools and procedures have been created for the emerging concept of Patient and Family Advisory Boards, including processes for screening and interviewing patients, establishing expectations for patient participation, and building skills in problem solving. The Advisory Board concept will be introduced to patients and families dealing with mental health concerns as well as patients participating in the Million Hearts. Patient engagement in Million Hearts may provide valuable feedback about improving adherence to a plan of care, tailoring program interventions for patients at varying levels of readiness for change, and helping patients identify community resources, such as exercise programs and farmers' markets, that complement and enrich the clinical component of Million Hearts.

UC Davis Medical Center participates in the Greater Sacramento Care Coordination Collaborative that convenes hospitals, nursing homes, home health organizations, physician groups, pharmacies, and community-based organizations. Members of the collaborative engage in conversation and action to reduce readmissions through improving care transitions with an initial focus on medication management. This collaborative will address improvements in: 1) medication reconciliation, 2) the timely transfer of an updated medication list across care transitions, and 3) ensuring patients have their medications filled before their first home health visit. Other organizations involved in the collaborative are Sutter Health and Dignity Health.

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.

The UC Davis Medical Center used DSRIP to improve its procedures for collecting race, ethnicity, and language data in primary care settings as well as exploring opportunities for soliciting sexual orientation and gender identity information during brief patient-physician interactions.

With PRIME, additional university resources will be brought to bear on the projects. One resource, the Center for Reducing Health Disparities, has a wide-ranging focus on health disparities that includes an emphasis on improving access, detection, and treatment of mental health problems within the primary care setting. The Center also explores the intersection depression with chronic illnesses such as diabetes, cancer, and HIV/AIDS. The Center is led by Sergio Aguilar-Gaxiola, MD, PhD, an internationally renowned expert on mental health in ethnic populations. Dr. Aguilar-

Gaxiola is also a resource for presenting culturally and linguistically sensitive information to consumers and their families, health professionals, service administrators, and policy makers. An additional resource in developing culturally competent care teams is David Acosta, MD, associate vice chancellor of diversity and inclusion. Dr. Acosta, a family physician by training, leads all health-system operations to increase diversity in the UC Davis School of Medicine, the Betty Irene Moore School of Nursing, the UC Davis Medical Center, and the physician practice group.

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.

Quality improvement at UC Davis Medical Center is rooted in the tenets of the scientific method. Problems are identified in areas of strategic importance, including readmissions reduction and improving patient experience, that are supported by interprofessional teams of physicians, nurses, medical assistants, pharmacists, health coaches, performance improvement consultants, and allied health professionals in inpatient and ambulatory settings. Beyond the early team building and problem solving stages, groups focus on:

1. Identification and implementation of evidence-based guidelines and materials,
2. Translation of sustainable best practices to policy and procedure,
3. Small tests of change involving new processes and algorithms that emerge from evolution in practice,
4. Development of clinical decision support tools into EHR order sets, and
5. Monitoring variation in processes to sustain improvements over time.

The combination of these five steps results in processes that are constantly adapting to changes in the environment owing to new payment models, regulatory requirements, patient preferences, and a broader awareness of high-value care. The UC Davis Medical Center is enthusiastic about the changes in practice endorsed by PRIME and is a willing partner in customizing these practices to the needs of the broader Sacramento community.

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)

UC Davis Medical Center recognizes the access barriers for behavioral health services for many of our primary care patients and the high rates of behavioral health comorbidity for our patients with chronic illness. This project supports the current work of faculty psychiatrists who are trained to implement the collaborative care model within primary care clinics. These champions have created an initial framework for behavioral health integration that is ready for scaling to our entire primary care population.

We will take the following steps to reduce barriers for behavioral health care:

1. Integrate screening tools and clinical decision support for depression into our electronic health record (EHR) using PHQ2 and PHQ9. The technical build and workflow design should be completed in DY11. Spread across all our clinical offices is expected by mid DY13.
2. Use similar methods for anxiety and substance abuse screening beginning in DY13.
3. Utilize the Care Coordination Program to support follow-up and successful treatment for depression. Health coaches will provide motivational interviewing for patients at each office by the end of DY12. Care managers will assist with external referrals or assist the primary care physician (PCP) in collaborative care

utilizing the consulting psychiatrist at regular interdisciplinary meetings. We will use our EHR care management module to track follow-up and warm handoffs beginning in DY12.

4. Pilot a version of the TEAMCARE model for our most complex chronic illness patients with structured treatment to target approaches for diabetes/hypertension and depression beginning in DY13.
5. Provide the primary care teams with continuing education using collaborative care psychiatrists. We will provide two small group seminars to each office in DY11 and begin e-consultation for psychiatry in DY12.
6. Engage patients and their families in system redesign for integrated behavioral health using our PCMH focus groups in DY11 and our PCMH Patient Advisory Board in DY12.

Target Population. Our target population is patients who screen positive for depression using the PHQ9. Within this population, we will offer tiered approaches based on patient severity and preference. Health coaches will assist the patients with mild depression to ensure engagement, appropriate education, and follow-up with their PCP. Patients with moderate depression can be followed by our interdisciplinary nurse/social worker team, with the psychiatrist providing collaborative guidance. For our patients with severe depression, we will create expedited access to designated psychiatrists in our community or embedded in the primary care office, as well as offering non-traditional visits through telepsychiatry. Our educational seminars will help disseminate shared evidence-based clinical pathways for depression.

Vision for Care Delivery. We intend to increase our internal capacity for behavioral health and improve our external relationships and handoffs to community providers. This effort will result in more timely access to care for behavioral health problems. Our project will also help patients with chronic illness and depression become more activated, leading to improved patient outcomes and lower costs.

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

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

Check, if applicable	Description of Core Components
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 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.

Check, if applicable	Description of Core Components
Not Applicable	**1.1.9** Increase access to Medication Assisted Treatment (MAT) for patients with alcohol and opioid addiction to assist in stabilizing their lives, reducing urges or cravings to use, and encourage greater adherence to treatment for co-morbid medical and behavioral health conditions. For alcohol use disorders these medications include naltrexone, acamprosate, and disulfiram. For opioid addiction, medication assisted treatment (MAT) includes maintenance treatment with methadone and buprenorphine.
Not Applicable	**1.1.10** Ensure the development of a single treatment plan that includes the patient's behavioral health issues, medical issues, substance abuse, social and cultural and linguistic needs. This includes incorporating traditional medical interventions, as well as non-traditional interventions such as gym memberships, nutrition monitoring, healthy lifestyle coaching, or access to culturally and linguistically appropriate peer-led wellness and symptom management groups.
Not Applicable	**1.1.11** Ensure a culturally and linguistically appropriate treatment plan by assigning peer providers or other frontline worker to the care team to assist with care navigation, treatment plan development and adherence.
Not Applicable	**1.1.12** Ensure that the treatment plan: • Is maintained in a single shared Electronic Health Record (EHR)/ clinical record that is accessible across the treatment team to ensure coordination of care planning. • Outcomes are evaluated and monitored for quality and safety for each patient.
Applicable	**1.1.13** Implement technology enabled data systems to support pre-visit planning, point of care delivery, care plan development, population/panel management activities, coordination and patient engagement. Develop programs to implement telehealth, eReferral/eConsult to enhance access to behavioral health services.
Applicable	**1.1.14** Demonstrate patient engagement in the design and implementation of the project.
Applicable	**1.1.15** Increase team engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on care model.

Check, if applicable	Description of Core Components
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)

This project supports UC Davis Medical Center's ongoing efforts to provide care using the nationally recognized National Committee for Quality Assurance (NCQA) patient-centered care medical home (PCMH) model. This project will also help us shift from providing reactive to proactive care by focusing on population health management and patient engagement.

We will take the following steps to improve the quality of care we provide to our primary care patients:

1. Reapply for NCQA PCMH recognition, starting in DY12.
2. Refine the team-based care model, which includes health coaches, care managers, social workers, psychiatrists, and pharmacists. We will empower all clinical support staff to make recommendations for change and implement practice improvement processes. This work will start in DY11 and continue into DY12 and 13.
3. Enhance our ability to track clinical quality and resource utilization measures. We will develop a dashboard displaying measures that will be shared with the leadership teams, providers, and front-line staff. Additionally, the EHR and related technology will be used to improve preventive service outreach, identification of health disparities, and pre-visit planning. This work will start in DY12.
4. Engage patients and their families in the redesign process of preventive service outreach and health behavior change support through focus groups and our Patient Advisory Board. This work will start in DY11 and continue into DY12 and 13.

Target Population. Our target population is patients who have a PCP and have been seen at our primary care clinics. We will begin this work by: piloting new workflows, creating provider and staff training and resources, and then rolling them out to other clinic sites. This project will interact closely with the efforts of the behavioral health integration, chronic pain management, and complex care management projects for our high-risk patients to ensure sustainable, systematic, and unified changes.

Vision for Care Delivery. The goal is to have patients share in care-related decision making with the support of a care team. The care team will provide targeted interventions with the use of patient education and self-management tools. The development and distribution of reports will support our efforts to meet patients'/families' needs and coordinate their care across health systems. This project will also help us identify and integrate technological advancements to improve efficiency and effectiveness. The delivery of care will include the evidence-based guidelines for preventative and chronic care and rapid cycle quality improvement efforts. We will also incorporate the voice of the patient in our practice transformation efforts by pursuing patient involvement through a variety of approaches.

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.
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).

Check, if applicable	Description of Core Components
Not Applicable	**1.2.6** Enable prompt access to care by: • Implementing open or advanced access scheduling. • Creating alternatives to face-to-face provider/patient visits. Assigning frontline workers to assist with care navigation and non-clinical elements of the care plan.
Applicable	**1.2.7** Coordinate care across settings: • Identification of care coordinators at each primary care site who are responsible for coordinating care within the PCMH as well as with other facilities (e.g., other care coordinators or PCMH/DPH/DMPH high risk care managers): o Establish onsite care/case managers to work with high risk patients and their care teams, or develop processes for local care coordinators to work with a central complex care management program for these patients Implement processes for timely bi-directional communication and referral to specialty care (including mental health and substance use disorder services), acute care, social services and community-based services.
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)).
Applicable	**1.2.10** Engage patients using care plans, and self-management education, and through involvement in the design and implementation of this project.

Check, if applicable	Description of Core Components
Applicable	**1.2.11** Improve the accuracy and completeness of race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI) data, and use that data to identify and reduce disparities in one or more Primary Care Redesign project metrics by: • Adding granular REAL and SO/GI data to demographic data collection processes and training front-line/registration staff to gather complete and accurate REAL/SO/GI data. • Developing capacity to track and report REAL/SO/GI data, and data field completeness. • Implementing and/or refining processes for ongoing validation of REAL/SO/GI data. • Developing capacity to stratify performance metrics by REAL/SO/GI data and use stratified performance data to identify disparities for targeted interventions. • Developing capacity to plan and implement disparity reduction interventions with input from patients and community stakeholders. • Developing dashboards to share stratified performance measures with front-line staff, providers, and senior leadership.
Applicable	**1.2.12** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

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

UC Davis Medical Center supports this project because of the need to improve specialty access for our patients and hand-offs between PCPs and specialists. Lack of timely access to specialty care can have a negative impact on health outcomes overall. This project will strengthen our current innovation efforts toward the application of non-traditional visits in our strategy to meet patient needs. This project also overlaps our shared efforts in implementing e-consults across PRIME partners, including the UC Health Systems and SF General Hospital. Project 1.3 also aligns with PCMH methodologies and extends its principles into specialty care.

We will take the following steps to improve our efforts toward specialty care redesign:

1. Increase use of non-traditional visits, which may include e-consults, e-visits, shared medical visits, and telemedicine services. This work will begin in DY11 and continue to expand with the rollout of new specialties through DY12 and 13.

2. Improve specialty-PCP handoffs to meet needs of patients by establishing consistent referral guidelines and ongoing dedicated educational relationships. This work will begin in DY12.
3. Engage staff, including referral coordinators and new patient coordinators (ie, front-line workforce), to implement closed-loop processes. We will develop and improve pathways to ensure all requests are addressed and outcomes are communicated back to the PCP. This work will begin in DY12.
4. Enhance technology-enabled data systems to track referral turnaround rates and e-consult rates by practice. This work will begin in DY11.

Target Population. Our target population is all patients seeking specialty care at UC Davis Medical Center. This includes patients who have a PCP at one of our primary care clinics as well as patients referred to us from elsewhere. This population will include many high-risk patients served by PRIME Project 2.3 focused on complex care management. We will incorporate common referral processes and provide warm transfers.

Vision for Care Delivery. First, the non-traditional visit strategies will expand our current specialty access for our patients, improve efficiency, and build lines of communication between PCPs and specialty care physicians. Next, the care team, including health coaches and care coordinators, will help patients navigate across the continuum of care by connecting patients to other departments, specialties, and community agencies.

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

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

Check, if applicable	Description of Core Components
Not Applicable	**1.3.4** Engage primary care providers and local public health departments in development and implementation of specialty care model.
Not Applicable	**1.3.5** Implement processes for primary care/specialty care co-management of patient care.
Applicable	**1.3.6** Establish processes to enable timely follow up for specialty expertise requests.
Applicable	**1.3.7** Develop closed loop processes to ensure all requests are addressed and if in person visits are performed, that the outcome is communicated back to the PCP.
Not Applicable	**1.3.8** Ensure that clinical teams engage in team- and evidence-based care.
Applicable	**1.3.9** Increase staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the care model.
Applicable	**1.3.10** Develop and implement standardized workflows for diversified care delivery strategies (e.g., shared medical visits, ancillary led services, population management, telemedicine services) to expand access and improve cost efficiency.
Not Applicable	**1.3.11** Adopt and follow treatment protocols mutually agreed upon across the delivery system.
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.

Check, if applicable	Description of Core Components
Not Applicable	**1.3.15** Improve medication adherence.
Not Applicable	**1.3.16** Implement population management strategies for patients in need of preventive services, with chronic conditions, or with recurring long term surveillance needs.
Applicable	**1.3.17** Implement or expand use of telehealth based on DPH/DMPH capacity to address patient and PCP barriers to accessing specialty expertise. Implement a telehealth platform with communication modalities that connect between specialty care and primary care (e.g., eConsult/eReferral).
Not Applicable	**1.3.18** Demonstrate engagement of patients in the design and implementation of the project.
Not Applicable	**1.3.19** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.
Applicable	**1.3.20** Test use of novel performance metrics for redesigned specialty care models.

☒ 1.5 – Million Hearts Initiative

UC Davis Medical Center selected this project because high blood pressure affects approximately 35% of our primary care population. This project also aligns with a current cardiovascular risk reduction pilot, which incorporates a pharmacist and health coach as part of the care team model. The pilot also includes use of a smart blood pressure monitor as a self-management tool for the target population. We hope this pilot provides positive outcomes that will guide our on-going efforts for the PRIME project. Because of the increased risk for heart disease and stroke as a consequence of high blood pressure, we recognize the need to improve how we provide educational resources on risk factors and self-management tools to our patients with high blood pressure.

Our planned implementation approach includes:

1. Improving our blood pressure competency training for all clinical support staff members (ie, medical assistants, LVNs, and nurses). This will include the engagement of new hires as well as current staff. We expect to begin this work in DY12.
2. Organizing a workgroup to review the results of the pay-for-performance pilots, implementing the studied workflows, and expanding the refined care team model to additional sites. This will start in DY12 and be spread across the system through DY13.
3. Using our organization's value stream improvement structure for continual performance feedback to the care teams based on PCMH registry reports and nationally recognized preventative service benchmarks. This will start in DY11.
4. We will employ local, state, and national resources and methodologies to improve population health, including the nationally recognized Million Hearts Initiative and the local chapter of the Right Care Initiative. This work will start in DY11.

Target Population. Our main target population is patients with a diagnosis of hypertension or other recognized cardiovascular risk factors. We will use reports from our EHR to identify the patients and focus our quality improvement efforts. We will also include the target population as part of our previsit planning outreach reports. We will incorporate the nationally recognized Million Hearts Initiative tools and action guides as a template for implementing best practices across all clinics.

Vision for Care Delivery. PRIME will enable us to improve health outcomes for this high-risk population through process redesign. We will engage staff by providing training and education on the importance of population health management. We will provide educational tools and resources to support patient needs during office visits and at home.

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

Check, if applicable	Description of Core Components
Applicable	**1.5.1** Collect or use preexisting baseline data on receipt and use of targeted preventive services, including any associated disparities related to race, ethnicity or language need.
Applicable	**1.5.2** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to the US Preventive Services Task Force (USPSTF) A and B Recommendations.
Not Applicable	**1.5.3** Improve access to quality care and decrease disparities in the delivery of preventive services.
Applicable	**1.5.4** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
Applicable	**1.5.5** Adopt and use certified electronic health record systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population management approaches (e.g., in-reach, outreach) to reduce gaps in receipt of care.
Applicable	**1.5.6** Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.
Applicable	**1.5.7** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. • Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts.
Applicable	**1.5.8** Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.

Please complete the summary chart:

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

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

☒ 2.1 – Improved Perinatal Care (required for DPHs)

This project is valuable to UC Davis Medical Center because of the need to decrease maternal morbidity and mortality nationally. The medical center cares for a diverse population of women, many with high-risk pregnancies. Utilizing a multidisciplinary quality focused team, we will implement evidence-based strategies to improve the care of mothers and their babies.

Our focused core components will be:

1. *Maternal morbidity and mortality related to obstetrical hemorrhage*. Obstetrical hemorrhage is the leading cause of preventable maternal mortality. The UC Davis Medical Center is committed to improving the process for identification of and communication with women at risk for obstetrical hemorrhage. In a complex health care setting, communication is essential to improving patient safety and quality. To achieve this, we will:
   a. Build an obstetrical hemorrhage risk assessment in the EHR by DY13.
   b. Train staff and providers on an evidenced-based obstetrical hemorrhage risk assessment through small group education in DY14.
   c. Deploy the obstetric hemorrhage risk assessment through the EHR by DY14.

2. *Cesarean section rates*. Prevention of the first cesarean section is a key component to decreasing the rate of maternal delivery complications. UC Davis Medical Center will implement the California Maternal Mortality Care Collaborative (CMQCC) Supporting Vaginal Birth and Reducing Primary Cesarean Toolkit. The CMQCC toolkit will guide our interventions to support vaginal birth for primiparous women whenever possible. To achieve this, we will:

a. Complete a gap analysis comparing current practices to recommended practices. A review of the toolkit will be completed and compared with current practices by the end of DY12.
b. Convene a multidisciplinary team in DY13 to set priorities and develop an improvement plan.
c. Implement identified changes and engage patients and their families in the processes that will optimize supporting vaginal birth by the end of DY14.

3. *Outpatient Perinatal care.* The UC Davis Medical Center will implement a patient-centered approach to care for pregnant women before and after birth. To achieve this, we will:
   a. Complete a gap analysis comparing our current practices across our various outpatient clinics that provide prenatal and postpartum care. This work will begin in DY 12.
   b. Establish a work group to analyze findings from the gap analysis, set priorities, and develop an improvement plan. This work will begin in DY13.
   c. Implement a patient-centered care model by engaging patients and their families in the process improvement. This work will begin in DY14.

Target Population. The target population will be women who present to labor and delivery (L&D) for their birth admission and women accessing OB care in any of our clinics. All women will be assessed for risk of obstetric hemorrhage using an evidence-based risk assessment tool. The OB hemorrhage risk tool will identify women at low, medium, and high risk of obstetric hemorrhage. Primiparous women who are low risk will be supported to have a vaginal birth.

Vision for Care Delivery. Our vision is to provide excellent perinatal care through standardization of care, collaboration across disciplines, and implementation of best practices, from L&D to our outpatient clinic sites. Our goal is to provide tools to the health care team that will enable them to implement evidenced-based care to our diverse perinatal population.

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).
Not 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.

Check, if applicable	Description of Core Components
Applicable	**2.1.3** Encourage best practice and facilitate provider education to improve cesarean section rates, and decrease inequities among cesarean section rates. Participate, as appropriate, in statewide QI initiatives for first-birth low-risk cesarean births.
Not Applicable	**2.1.4** Coordinate care for women in the post-partum period with co-morbid conditions including diabetes and hypertension.

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

At UC Davis Medical Center we have assembled a multidisciplinary team to work on the development of our transitions of care (TOC) programs and there are five workgroups that meet regularly to address aspects of the care transition process. One of the workgroups is focused on medication management and reconciliation. The workgroup is incorporating the PRIME program and metrics into its efforts.

In DY11-13, we will participate in the second Multi-Center Medication Reconciliation Quality Improvement Study (MARQUIS 2) beginning in July 2016. MARQUIS 2 is an initiative funded by Agency for Healthcare Research and Quality (AHRQ) to assist hospitals in improving medication reconciliation. We will focus on policy revisions, workflow modifications, education, and improved reporting for medication reconciliation.

Also in DY11-12, we will utilize UC Davis Medical Center's value construct huddle (VCH) to track performance in the H-CAHPS care transition questions. The VCH is a weekly multidisciplinary huddle with key stakeholders in the medical center who meet to monitor and direct changes related to a variety of quality outcomes, including 30-day all-cause readmissions. Additionally, the TOC program will develop standardized discharge packets, explore the expansion of care navigators, implement a post-discharge phone call methodology, and track the H-CAHPS care transitions questions.

The focus for DY12-13 is to use technology, education, competencies, and existing resources to improve outcomes. Then, utilizing the data that are collected during the initial phase, we will explore system changes to meet our goals for each of the metrics. Our first phase will target the main hospital, utilizing pharmacy technicians and pharmacists to provide medication reconciliation for a large subset of our patients. These patients will be provided care at admission and at discharge.

In the future, we will shift our focus to the ambulatory care areas to improve medication reconciliation during specialty and primary care visits. Specifically, we will use the data

we collect in our first year from our MARQUIS 2 implementation, and the results of the clinician competencies to determine our ambulatory/community care plans. We will also collaborative with a TOC care transitions workgroup to provide assistance for the medication aspect of their pilot programs, determining possible best ways to intervene. Future ambulatory plans could include providing medication calendars for patients, providing further education to clinicians and patients on the value of medication reconciliation and/or providing directed pharmacy resources for that area.

Target Population. We are targeting the entire medical center population for the provision of care transition interventions. Our plan is to focus on high-risk patients first, but many of our changes to discharge and medication reconciliation processes will affect the entire medical center. There will be two phases for our work: First, focus on admit and discharge, while we audit the ambulatory areas; second, focus on the ambulatory care setting and improving medication reconciliation in the primary care clinics and the specialty clinics.

Vision for Care Delivery. With the operationalization of the above tools and a streamlined system for staff to ensure safe and effective medication reconciliation, our system improvements will protect patients from medication errors in inpatient and outpatient settings. Our improved care transition program will support patients throughout the continuum of care and provide better information to PCPs when they see their patients after discharge. Patients will have the opportunity to become more involved in their health care, and PCPs will be better prepared to respond to post-discharge needs and follow-up.

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.

Check, if applicable	Description of Core Components
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.
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.
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.

Check, if applicable	Description of Core Components
Not Applicable	**2.2.8** Engage with local health plans to develop transition of care protocols that ensure: coordination of care across physical health, substance use disorder and mental health spectrum will be supported; identification of and follow-up engagement with PCP is established; covered services including durable medical equipment (DME) will be readily available; and, a payment strategy for the transition of care services is in place.
Not Applicable	**2.2.9** Demonstrate engagement of patients in the design and implementation of the project.
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)

UC Davis Medical Center recognizes the need to provide care coordination services to its most complex and high-risk patients. Given the new emphasis on value over volume in alternative payment models, we must improve the ability of the health care delivery system to achieve better patient outcomes, including fewer 30-day hospital readmissions and return visits to the ED, at lower cost. This project aligns with our PCMH and enables us to develop a standardized risk stratification methodology. Caring for our high-risk patient population will require the use of technology to invoke services based on patient need and provide routine monitoring of patients' engagement in the program.

Our goal is for the development and integration of an enhanced care team across all clinic sites. Our care management team will consist of on-site and centralized services. High risk patients will be discussed at weekly interdisciplinary team meetings.

a. Health Coach will be on-site at the clinic. They will be the liaison to the interdisciplinary team and will do a warm hand-off to care coordination, prepare high risk patients for office visit with PCP and facilitate navigation

and follow-up. They will also activate and engage patients, families, and/or the caregivers in disease self-management.

b. Pharmacist will provide comprehensive medication reconciliation and assist with medication access issues.
c. RN will initially assess patient needs and develop the care plan, in alignment with the Primary Care Physician's and the patient's goals. The nurse will also use scheduled outreach for high risk population management.
d. Social worker will assess psycho-social needs, address barriers to care, and facilitate connections to community resources.
e. Psychiatrist will support the integration of behavioral health into the care plan through consultation and care recommendations.

Our planned implementation approach includes the following:

1. Implement technology-enabled data systems to efficiently identify targeted patient populations based on risk. This work will start in DY12.
2. Integrate a patient engagement assessment tool to identify patient's readiness for support. Efforts in this area will begin in DY12.
3. Develop a multi-disciplinary care team that will manage the care of each assigned patient and tailor care using tiered interventions that are deployed based on risk. This work will begin in DY11.
4. Ensure systems and care teams are in place to support system navigation and provide patient linkage to culturally appropriate physical health, mental health, and social services including those in the community. We will ensure follow-up and retention in support services and promote adherence to medications and treatment plans. These efforts will start in DY12 and be spread across the system through DY13.
5. Coordinate post-discharge care following ED and hospital admissions for seamless transitions of care. A committee to lead these efforts was established in DY11 will continue through DY13.

Target Population. Our target population is focused on patients with multiple medical conditions, behavioral health problems, and socioeconomic barriers to self-management. All patients will be stratified and assigned to a level of care based on a risk tool integrated in the EHR. We intend to use a population management system within the EHR to help us identify and address care gaps for our target population. This population may have characteristics in common with patients served by our project on behavioral health integration in primary care.

Vision for Care Delivery. Once our target population is risk stratified, the patient will be engaged and activated by a multidisciplinary team consisting of a health coach, registered nurse, social worker, and psychiatrist who will communicate and collaborate

with the PCP. The team will use motivational interviewing to develop a patient-centered action plan to improve chronic disease self-management skills. Next, we hope to incorporate a patient activation assessment to measure patient readiness and track changes over time. Additionally, this PRIME project will enable us to support patients across the care continuum to ensure connections are made and resources accessed both within and outside the UC Davis Medical Center.

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

Check, if applicable	Description of Core Components
Applicable	**2.3.1** Develop a complex care management program at one site or with one defined cohort, or expand an existing program from a pilot site to all sites or to additional high-risk groups and demonstrate engagement of patients in the design and implementation of the project.
Applicable	**2.3.2** Utilize at least one nationally recognized complex care management program methodology.
Applicable	**2.3.3** Identify target population(s) and develop program inclusion criteria based on quantitative and qualitative data (e.g., acute care utilization, lack of primary care utilization, number of high-risk medical mental or SUD conditions, polypharmacy, primary care input, functional status, patient activation, social support or other factors). Include patient factors associated with a higher probability of being impacted by complex care management.
Applicable	**2.3.4** Conduct a qualitative assessment of high-risk, high-utilizing patients.
Applicable	**2.3.5** Establish data analytics systems using clinical data sources (e.g., EHR, registries), utilization and other available data (e.g., financial, health plan, zip codes), to enable identification of high-risk/rising risk patients for targeted complex care management interventions, including ability to stratify impact by race, ethnicity and language.
Applicable	**2.3.6** Develop a multi-disciplinary care team, to which each participant is assigned, that is tailored to the target population and whose interventions are tiered according to patient level of risk.
Applicable	**2.3.7** Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets.

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

☒ 2.6 – Chronic Non-Malignant Pain Management

UC Davis Medical Center selected this project because chronic non-malignant pain is a common problem for many of our primary care patients. We also selected this project because the Sacramento community has a high rate of prescription opiate misuse. Sacramento has a narcotic overdose rate that is ranked in the top five cities in the state. In the Sacramento County, emergency room visits related to prescription opioids have risen from 150 in 2006 to 270 in 2013; hospitalizations have increased from 105 in 2006, to 2010 in 2013; and the overdose rate is 3.3 per 10,000 residents.[4] The County of Sacramento recently hosted a regional collaborative to address this issue. UC Davis Medical Center recognizes the need to improve treatment safety for our patients with

chronic non-malignant pain. We also understand the need to educate and support patients with chronic pain.

We will take the following steps to improve the quality of care we provide to patients with chronic non-malignant pain:

1. Implement a standardized pain care agreement across the organization. This work will be completed in DY11.
2. Develop standardized processes and guidelines for prescription of opiates that are consistent with current evidence and California law. This will begin in DY11.
3. Implement technology-enabled data systems and reports to identify patients for population management, previsit planning, and care coordination. This will start in DY12, with broad dissemination occurring through DY13.
4. Develop an organized system of resources for chronic non-malignant pain: education, multi-modal therapy, and behavioral health support. This work will begin in DY12.

Target Population. Our target population is patients who have a diagnosis of chronic non-malignant pain. We will use reports from our EHR to identify patients at highest risk for adverse outcomes related to their medication. We will provide this group of patients education and support to make better informed choices about pain therapy. This population will include many patients served by our project on behavioral health integration in primary care. We will incorporate best practices for this overlapping population to make sure that depression and anxiety treatment are included in each patient's care plan.

Vision for Care Delivery. We provide patient-centered care for chronic non-malignant pain that is holistic and safe. Practices use a team approach for chronic pain that centers on shared workflows and standards based on safe practice.

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

Check, if applicable	Description of Core Components
Applicable	**2.6.1** Develop an enterprise-wide chronic non-malignant pain management strategy.
Not Applicable	**2.6.2** Demonstrate engagement of patients in the design and implementation of the project.
Not Applicable	**2.6.3** Implement or adapt a state or nationally recognized methodology for the assessment and management of chronic pain.

Check, if applicable	Description of Core Components
Applicable	**2.6.4** Implement protocols for primary care management of patients with chronic pain including: • A standard standardized Pain Care Agreement. • Standard work and policies to support safe prescribing practices. • Comprehensive pain history including psycho/social evaluation, functional evaluations, care plan, pain medication risk/benefit informed consents, ongoing monitoring of plan/outcomes (e.g., use of standardized monitoring template for follow-up visits for CNP), aberrant behavior screening and management protocols. • Guidelines regarding maximum acceptable dosing.
Applicable	**2.6.5** Provide culturally, linguistically and literacy level-appropriate patient education on the pathology of chronic pain, rationale for rehabilitation and expected goals of treatment.
Applicable	**2.6.6** Coordinate a chronic pain care team that minimally consists of a physician champion and medical support staff. Suggestions for care clinicians from other disciplines include occupational and physical therapy, behavioral health, pharmacy, substance use disorder specialists, neurology, occupational medicine, anesthesiology/pain management, home care, social work, and physical medicine and rehabilitation.
Applicable	**2.6.7** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, and team based population/panel management and care coordination.
Applicable	**2.6.8** Determine population ICD-9/ICD-10 codes for data collection that is unique to patients with chronic pain on opioids and develop a registry for pain assessments, care agreements, medication refill standing orders and urine toxicology screening.
Not Applicable	**2.6.9** Utilize provider activity report card to provide feedback to providers on how their chronic pain management practice compares to peers and benchmarks.
Not Applicable	**2.6.10** Establish a policy for monitoring and maintaining opioid agreements for prescription refills with other clinics, pharmacies, dentists and specialists.
Not Applicable	**2.6.11** Develop a process for scheduling pain focused follow-up patient visits to ensure that patients receive refills in a timely manner while also receiving recommended monitoring for signs of diversion or misuse.
Applicable	**2.6.12** Develop staff and clinician training regarding the organization's process for managing patients with chronic non-malignant pain.

Check, if applicable	Description of Core Components
Not Applicable	**2.6.13** Train providers to identify signs of prescription opioid use disorders and provide treatment options for patients diagnosed with opioid use disorders, including suboxone treatment, referral to methadone maintenance, referral to inpatient and outpatient substance use disorder treatment facilities, and referral to needle exchanges.
Applicable	**2.6.14** Develop and implement protocols for prescribing naloxone to patients receiving opioids for chronic pain.
Not Applicable	**2.6.15** Identify standardized multidimensional pain assessment, functional assessment, psychological assessment, and opioid assessment tools that meet the needs of the care clinicians and are appropriate for the patient populations.
Applicable	**2.6.16** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. Timely, relevant and actionable data is used to support patient.

Please complete the summary chart:

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

Section 4.3 – Domain 3: Resource Utilization Efficiency

☒ 3.2 – Resource Stewardship: High Cost Imaging

Through the high-cost imaging project, UC Davis Medical Center will improve the diagnostic approach to three common clinical conditions: 1) suspected pulmonary embolism (PE), 2) benign headache, and 3) non-traumatic low back pain (stratified by red flag findings). Despite the existence of decision rules and evidence-based guidelines addressing these clinical scenarios, the approach to imaging each of these patient populations has significant variance among providers. It is also widely accepted that providers over-utilize imaging when evaluating these conditions. By incorporating evidence-based decision making into the evaluation process, this project aims to decrease variance and improve the value of care for patients being evaluated. For success, we will use the following approach:

1. Review the best available evidence and best-practice algorithms for each condition.
2. Establish diagnostic algorithms, based on the evidence, for each condition and align the algorithms with the PRIME metrics in order to determine best practices. This will begin in DY11 and be finalized by early DY12.
3. Assess utilization data at multiple points, including pre- and post-implementation of the diagnostic algorithms. The team will conduct chart reviews to determine baseline ordering patterns and assess utilization trends. Where needed, we will develop a methodology for automatic data capture from the EHR. Initial chart review and baseline data will be completed in DY11; the automatic data capture methodology will be completed in DY12.
4. Educate relevant health system providers on evidence-based practice for each condition through informational electronic mailings, multidisciplinary grand rounds, and staff training. This work will begin in DY12.
5. Incorporate the algorithms into clinical decision support tools in the EHR. We will take advantage of the Medicalis software implementation, when applicable. Medicalis is a clinical decision support tool. This will begin in DY12 and continue into DY13.
6. Track ongoing compliance with the algorithms and provide individual feedback to providers. This will be an ongoing process beginning in DY12 and continuing throughout the project.

Target Population. Variance in the diagnostic work-up of patients with potential PE, benign headache, and non-traumatic back pain leads to increased utilization of diagnostic imaging. For our patients, unnecessary tests may have deleterious effects, such as radiation exposure and intravenous contrast-related complications. The results of those tests can lead to additional testing or treatments that may not be indicated and

pose additional health risks; examples include medications, surgeries (in the case of back pain), and anti-coagulation (in the case of clinically insignificant PE).

Vision for Care Delivery. Our goal is to increase the value of care our patients receive in both our ambulatory and acute care environments. By embedding clinical decision support in the EHR, we expect to decrease resource utilization and improve quality by decreasing radiation exposure and other adverse effects of unnecessary imaging studies. The implementation of process and outcome measure reporting will allow for trending the use of the tools and their impact on outcomes, guiding further improvement efforts.

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

Check, if applicable	Description of Core Components
Not Applicable	**3.2.1** Implement an imaging management program, demonstrating engagement of patients in the design and implementation of components of the project.
Applicable	**3.2.2** Program should include identification of top imaging tests whose necessity should be assessed for possible overuse. Criteria for assessment could include: • Frequency and cost of inappropriate/unnecessary imaging: o Appropriate Use: Beginning with state- or nationally-recognized models or guidelines (e.g., American College of Radiology Appropriateness Criteria, American College of Cardiology Appropriate Use Criteria) and incorporating pertinent local factors, programs will set out definitions for appropriateness. o Cost: Programs will identify imaging studies associated with high costs due to high cost per study or high volume across the system. • Unwarranted practice variation within the participating DPHs/DMPHs. Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed. • Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed. • Whether there are established, tested and available evidence-based clinical pathways to guide cost-effective imaging choices.

Check, if applicable	Description of Core Components
Applicable	**3.2.3** Establish standards of care regarding use of imaging, including: • Costs are high and evidence for clinical effectiveness is highly variable or low. • The imaging service is overused compared to evidence-based appropriateness criteria. Lack of evidence of additional value (benefits to cost) compared to other imaging options available to answer the clinical question.
Applicable	**3.2.4** Incorporate cost information into decision making processes: • Develop recommendations as guidelines for provider-patient shared decision conversations in determining an appropriate treatment plan. • Implementation of decision support, evidence-based guidelines and medical criteria to recommend best course of action.
Applicable	**3.2.5** Provide staff training on project components including implementation of recommendations, and methods for engaging patients in shared decision making as regards to appropriate use of imaging.
Applicable	**3.2.6** Implement a system for continual rapid cycle improvement and performance feedback that includes patients, front line staff and senior leadership.

Please complete the summary chart:

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

Section 5: Project Metrics and Reporting Requirements

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

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

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

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

Section 6: Data Integrity

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

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

Section 7: Learning Collaborative Participation

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

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

Section 8: Program Incentive Payment Amount

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

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

- DY 11 $ 58,433,200
- DY 12 $ 58,433,200
- DY 13 $ 58,433,200
- DY 14 $ 52,589,880
- DY 15 $ 44,701,398

Total 5-year prime plan incentive amount: $ 272,590,878

Section 9: Health Plan Contract (DPHs Only)

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

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

Section 10: Certification

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

Appendix- Infrastructure Building Process Measures

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

References

1. UC Davis Medical Center 2013 Community Health Needs Assessment (CHNA). Available at: https://www.ucdmc.ucdavis.edu/community_relations/pdf/2013-Community-Health-Needs-Assessment.pdf (accessed on 03/04/2016).
2. Sacramento County California QuickFacts from the US Census Bureau. Available at: http://www.census.gov/quickfacts/table/PST04215/0664000,06067 (accessed on 03/13/2016).
3. UC Davis Medical Center Hospital Summary Individual Disclosure Report (SIDR), 07/01/2013 – 06/30/2014, audited. Available at: https://siera.oshpd.ca.gov/FinancialDisclosure.aspx (accessed on 03/04/2016).
4. Reese P. See where California's heroin, opioid problems are worst. Sacramento Bee, August 17, 2015. Available at: http://www.sacbee.com/site-services/databases/article31324532.html (accessed on 04/01/2016).