
# 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** | University of California San Diego Health (UCSDH) |
| **Health Care System Designation** | 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.*

San Diego County benefits from having a richly diverse population, bringing with it the challenges and opportunities to improve the health and well-being for many people. San Diego County's most significant health care needs include those related to cardiovascular disease, type 2 diabetes, obesity and mental/behavioral health.

**Cardiovascular disease:** Heart disease is the leading cause of death in the United States; San Diego's rate of heart disease surpasses the California state average. In 2010, San Diego's rate of coronary care disease was 4.1% compared to state rate of 3.6%.

**Type 2 Diabetes:** While San Diego's age-adjusted prevalence rates for adult diagnosed diabetes are marginally lower than the California state rate (8.7% in San Diego (SD) vs. 8.9% in California in 2010); our death rates exceeded those expected in the state. For central, east and south San Diego County, the diabetic mortality per 100,000 population were all above 26.1, vs. 20.8 for the U.S. and 19.8 for California in 2010.

**Obesity:** Obesity is a risk factor for chronic diseases, including coronary heart disease and type 2 diabetes. The prevalence of obesity for central San Diego exceeds the state average (SD 29.3% vs. 24.0% for California in 2009). Rates of obesity are higher among the Hispanic and Black non-Hispanic populations. In

2008, the medical costs for obese individuals in the US were $1,429 higher than those of normal weight.

**Mental/Behavioral Health:** Suicide mortality rates for central San Diego exceed the California state average (SD 14.0/100,000 vs 9.6 for California 2009).

**Coverage:** In 2015, San Diego County had 665,865 Medi-Cal beneficiaries, an enrollment increase of 88,691 from 2014. For residents with insurance, UCSDH is concerned about access to care because there are provider shortages despite a local network of Federally Qualified Health Centers and numerous non-profit hospitals. Access is particularly challenging for the nearly 100,000 people in San Diego County who are not eligible for Medi-Cal due to immigration status, and the 40,000 eligible individuals who have not enrolled. San Diego County is one of the few counties in the state that does not have a county-run hospital. UCSDH by virtue of its central location and unique role as the region's only academic health system serves a disproportionate share of patients from at-risk communities. UCSDH aims to use PRIME as an opportunity to serve San Diego's diverse populations and communities in innovative ways that leverage UCSDH's unique capabilities and cultural competence.

### 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.*

UCSDH serves the diverse population of San Diego County with an estimated 3,227,496 residents. San Diego is the largest city in San Diego County and provides a home for 42% of the county's residents. We are the county's only designated public hospital, providing inpatient, acute, and ambulatory services to the metropolitan areas and a large rural population. Our tertiary and quaternary care expertise supports an even wider geographic footprint.

**Income:** The median household income for San Diego County in 2015 was $69,346. However, the median masks poverty. While high salaries are available to professionals in the tech, biotech, and health sectors, nearly 11% of the population's income fell below 100% of the federal poverty level.

**Race/Ethnicity and Language:** The population of San Diego County is diverse including 47% Non-Hispanic White, 33% Hispanic, 12% Asian & Pacific Islander, 4% African American, 0.5% Native American, and 3% Other. Local communities include Chaldean (Iraqi), Hispanics from Mexico, Central America, and South America and large Vietnamese, Filipino and African populations. Our translation services have been expanded through one of our prior Delivery System Reform

Incentive Payment (DSRIP) waiver projects. Currently, we are able to communicate in 215 languages utilizing in-person translation, phone language lines as well as real time video translation.

**Age:** SD County's age is similar to the California state average, with a median age of 35.3 years compared to 35.2 California. San Diego County's age breakdown is:

- 0-18 years (23%)
- 19-64 years (64%)
- 65 and over (13%)

**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.*

UCSDH is the region's only academic health system, with a combined capacity of 563 beds (operating under one license): UC San Diego Medical Center in Hillcrest (390 beds), Thornton Hospital (119 beds) and Sulpizio Cardiovascular Center (54 beds). Each location supports acute in-patient care, emergency services and a spectrum of outpatient primary and specialty medical and surgical services. Tertiary and quaternary services include heart, lung, liver, kidney and bone marrow transplantation and an internationally known pulmonary thromboenarterectomy program. Additionally, UCSDH has 23 clinic locations throughout the region.

UC San Diego Medical Center in Hillcrest houses multiple specialty care centers including the area's only Regional Burn Center, a Comprehensive Stroke Center, a Level III NICU, a Level I Trauma Center and the Owen Clinic, one of the nation's top HIV care programs.

The La Jolla campus houses Thornton Hospital, a general medical and surgical facility and Sulpizio Cardiovascular Center. This campus also contains the Moores Cancer Center, the region's only NCI-designated Comprehensive Cancer Care Center, and the Shiley Eye Institute, offering comprehensive ophthalmologic care.

In fiscal year 2015, our payor mix was: 32% Medicare, 40% Medi-Cal, 27% private insurance, and 1% other indigent care. UCSDH provided 28,043 acute inpatient discharges and 636,118 ambulatory care visits. The average length of stay for acute care was 5.9 days. The occupancy rate was 83% of available beds and 80% of licensed beds.

**2.4 Baseline Data.** *[No more than 300 words]*
*Describe the current resources that your entity has in place to collect, report and monitor performance data and how these resources will support PRIME clinical quality reporting requirements. Please specify any anticipated limitations or barriers*

*to meeting the PRIME reporting requirements and describe your proposed strategies to address these barriers.*

**Infrastructure:** In the past decade, UCSDH has established an elaborate clinical data warehouse that captures over 14,000 electronic health record (EHR) data tables. This enables real-time reporting on any discrete data element in our EHR (Epic) through data extraction using structured query language (SQL) programming from the EHR SQL database, Clarity. The organization has more than 20 certified EHR report writers, responsible for creating retrospective and real-time reports. Initially, there will be one data analyst dedicated to support the PRIME projects and we will scale up as needed. Our reporting will follow the processes of:

**Data Collection:** The EHR is the primary data source for the majority of the PRIME measures and reporting. PRIME will provide the organization with a unique opportunity to consolidate and streamline data collection for process and outcome measures that currently exist across diverse quality reporting programs, such as Meaningful Use, Pay for Performance (P4P), California Quality Maternity Care Collaborative (CQMCC) and Physician Quality Reporting System (PQRS). A few measures may require manual data abstraction or collaboration with the community and external organizations.

**Reporting:** UCSDH uses a range of real-time, monthly and quarterly dashboards and reports to track performance. For example, the “My Panel Metrics” dashboard is available to relevant providers at any time through the EHR. Most of these measures roll up to an Executive Team and/or Quality Council dashboard.

**Monitoring:** The analytics team, clinical experts and quality improvement team review data collection processes and outcomes. Performance is reviewed regularly to explore improvement opportunities and develop targeted action plans during interdisciplinary team or committee meetings. Performance will be monitored on a medical staff and executive leadership level.

**Challenge:** The most significant anticipated challenge to meeting the PRIME reporting requirements is the vast number and diversity of PRIME measures required for each PRIME project. This challenge will be overcome through the addition of dedicated analysts and report writers specifically assigned to PRIME projects, thereby leveraging the EHR for accurate reporting of metrics and performance.

## 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.*

   UCSDH has a vision to create an environment where the three academic missions – teaching, research, and clinical excellence – create a healthier world one life at a time.

   UCSDH will achieve patient and community health through four core goals: 1) providing outstanding outcomes and innovative patient-centered delivery 2) developing high value systems of care delivery 3) enhancing the patient experience through access and engagement and 4) delivering equitable care.

   PRIME offers UCSDH an opportunity to meet the following objectives: 1) readiness for the transition toward alternative payment models (APMs) and value based payment 2) capacity development in efficient and effective care delivery 3) integration of behavioral health 4) effective care coordination and 5) addressing health disparities in our community

   UCSDH will accomplish this delivery system transformation by designing, implementing, and measuring new systems and processes in order to support culturally competent, high value, patient centered care.

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

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

To accomplish our goals UCSDH aims to provide whole person care which is evidenced based. Whole person care will be accomplished through the integration of behavioral health, enhanced, effective care management across the continuum of care, and implementing innovation in care delivery including alternatives to face to face visits. To achieve our goal of equitable evidenced based care, we will leverage technology to standardize processes, implement clinical protocols, understand our REAL/SO/GI disparities and manage the health of our population. To improve care we will use risk stratification. For those with the greatest need, such as complex chronic and advanced illness, we will develop and implement targeted evidenced-based interventions. Value based care will be achieved through the effective use of resources, including management of high cost pharmaceuticals and antibiotic stewardship.

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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;*

PRIME speaks directly to UCSDH's vision of creating a healthy world through 1) ambulatory delivery system transformation 2) population health 3) complex care management and 4) effective resource utilization. A strategic priority for UCSDH is care delivery processes and infrastructures which support value based care and alternative care payment models, in alignment with future healthcare financing. PRIME projects in domains 1 and 2 will enable us to develop new screening tools, enhance data capture, implement new clinical protocols, improve communication processes and workflows, thereby promoting appropriate utilization, greater patient access and engagement, and reduced disparities in care. Prime projects for antibiotic stewardship (Project 4.3.1) and high cost pharmaceuticals (Project 4.3.3) will enhance evidenced based value driven care.

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

UCSDH selected multiple projects that inter-relate in order to build a highly coordinated health system that appropriately drives improved patient experience and health outcomes resulting in high value healthcare. By focusing on enhanced access, identification of need, protocol driven care and teamwork,

UCSDH will build resources that support behavioral health, case management, perinatal care, and advanced illness planning. This enhanced infrastructure will 1) support service to the underserved 2) address health disparities and 3) support community needs. UCSDH's system transformation is expected to result in measurable health and wellness improvement for patients and our community

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.*

At the end of 5 years, patients served by UCSDH will receive state of the art, high value healthcare that is accessible, patient-centered, evidence-based, data driven and provided by multi-disciplinary teams of providers. Through the transformation brought about by PRIME participation, UCSDH will create coordinated, multi-disciplinary teams, reduce healthcare silos, enhance evidence based decisions, institute standardized protocols and reduce care variability across the health system. UCSDH will have made measurable and significant impacts on cost drivers such as ED visits, unnecessary tests, hospital re-admissions, medication errors and preventable disease and medical condition exacerbations. These collective changes will provide the formula for clinical and financial sustainability.

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

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

San Diego's most significant community needs (refer to Section 2.1) include cardiovascular disease, type 2 diabetes, obesity and mental/behavioral health. Our projects were specially chosen to address these critical health care needs. Through PRIME, we will also organize our services to care for some of our community's most vulnerable citizens including those suffering complicated multi-system disease and those at the end of their lives. In order for UCSDH to address community needs; prevention, early identification, and patient engagement are critical. We recognize that lack of access to behavioral health services, case management, care transition support, perinatal, and primary care significantly contribute to adverse risk and outcomes. Over the course of PRIME, UCSDH aims to devise integrated, coordinated care delivery with measurable improved outcomes across the continuum that results in decreased cardiovascular disease, improved diabetic care, and enhanced behavioral health. Leveraging technology to enhance communication and changes in work flow we will also enhance care delivery with community partners, such as the Council of Community Clinics, representing the Federally Qualified Health Centers (FQHC) in San Diego County, and Medi-Cal Health Plans. Recognizing that the burden of preventable illness and chronic disease management will disproportionately fall upon specific REAL/SO/GI populations, we aim to add the capacity to monitor and implement disparity reduction interventions.

**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).*

Through previous experience with DSRIP, UCSDH gathered considerable experience with the implementation and governance of multiyear projects to enhance care delivery. A PRIME Executive Committee (PEC) composed of senior clinical and executive leadership will provide PRIME plan oversight. Each project within PRIME will be assigned a senior clinical champion, data steward, and an executive sponsor. The sponsor will be responsible for successful implementation, and reporting to the PEC on progress as well as identifying unexpected issues and resource needs. The PEC will routinely monitor all projects and assure project

timelines, implementation, and all reporting requirements are on track. PRIME will also report progress to the Quality Council, which is responsible for organizational quality and patient safety and which reports to the Governing Body. UCSDH's information services and decision support teams will oversee and assure that all data is timely and complete to support project success. UCSDH's current organizational goals include outstanding performance on national, state and local quality measurements in the hospital and ambulatory domains. Through adoption of a six-sigma approach to quality improvement, staff engagement is sought at all levels of the organization to drive both quality and safety improvement.

**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.*

UCSDH believes our PRIME stakeholders include patients, families, providers, staff, referring providers and health system administrators in San Diego County. Clinicians and data/measurement analysts were intimately involved with creating the PRIME plan for UCSDH. Each project has an assigned clinical and data/measurement lead. Project leads are expected to work with stakeholders in the respective clinical domains to assure that the projects, the goals and metrics are widely communicated throughout UCSDH and community partners. This enables key responsible individuals and stakeholders to develop projects in synergy and to coordinate local ownership as well as health system level integration for complete PRIME engagement. Patients have several modalities of engagement as a result of UCSDH focus on patient experience such as 1) membership in Patient Experience committee 2) participation in specialty area advisory committees in cardiology, HIV, and cancer and 3) patient surveys. UCSDH will continue to work with the FQHCs in our county. We also partner with San Diego County Public Health and other providers in San Diego on programs in cardiovascular disease prevention including the Right Care Initiative. We work closely with the CA Office of the Patient Advocate on multiple projects related to ambulatory care quality outcomes including those related to diabetes and cardiovascular disease.

**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.*

UCSDH is considered the foundation of the San Diego County health care safety net and deeply committed to diversity. As the designated public hospital, UCSDH is highly experienced in providing care to patients regardless of race, ethnicity,

gender, sexual orientation or language. Through PRIME, UCSDH will enhance REAL/SO/GI data acquisition enabling enhanced profiling and performance measurement of health disparities. Gaps in providing equitable health care across clinical services will be identified and addressed. Through enhanced organizational access to care coordination and navigators, UCSD expects to provide community-based outreach. In the selection process of these roles, UCSDH will assure that the work force adequately represents the population we serve. UCSDH has strong ties to San Diego County's diverse ethnic, racial and sexual identity communities including participation in key community based organizations. UCSDH's award winning HERE (Health + Education + Research = Empowerment) Initiative, is a collaboration of more than eighty organizations promoting health awareness, accessibility of healthcare, workforce diversity, research, and higher education for the underserved. UCSDH aims to enhance capabilities to draw from community resources to help problem solve methods to reduce health disparities identified during PRIME. Efforts to improve cultural competency and reduce health care disparities will include distilling and implementing best practices gathered from the literature, provider and staff training, and standardized procedures. We expect these efforts to also enhance patient engagement in the accurate capture of demographic data. We will seek feedback from patients on our progress through focus groups and patient satisfaction surveys.

**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.*

UCSDH believes that PRIME will enable a vision of high value healthcare delivered across the care continuum to support patient and community wellness and disease management. As with DSRIP, the changes in processes and infrastructure will become hardwired in the health system with an ongoing commitment of support.

UCSDH will include the PRIME Executive Committee from project inception to completion to develop a measurable and sustainable approach to re-organization and care management. UCSDH expects to apply a six-sigma approach to collaborative team-based care and multi-disciplinary learning, resulting in improvements in avoidable hospitalization, emergency department utilization, re-admission, use of high cost imaging, antimicrobial treatment, medication adherence, and transitions of care across the enterprise. UCSDH through the structures and processes implement during Prime will develop better systems of reporting and management leading to improved patient experiences, better clinical outcomes and safety, and effective, efficient and accessible care.

## Section 4: Project Selection

The PRIME Projects are organized into three Domains:

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

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

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

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

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

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

### Instructions

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

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

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

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

   *For DMPHs requiring infrastructure building metrics that are approved in the Prime Project Plan, 75% of PRIME funding for DY 11 will be based on the achievement of the approved DY 11 infrastructure building metrics through the final year-end report. Up to 40% of the total PRIME funding for DY12 will be based on the achievement of the approved DY 12 infrastructure building metrics through the mid-year and final year-end report. The proposed Process Measures should meet the following criteria:*
   - *Specific*
   - *Measurable: Must be able to demonstrate progress throughout the duration of the process metric measurement period.*
   - *Evidence-based: Measures should have a strong evidence-base that can linked process to outcomes.*

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

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

1. *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]*

   UCSDH will implement a collaborative care approach to integrating behavioral health treatment.

   Our planned implementation will include:
   - Screening. Universal screening for depression and substance abuse disorders will be implemented in the PRIME target population.
   - Co-location. Mental health clinicians will be placed in all primary care clinics. These mental health clinicians will use an established collaborative care approach to provide behavioral health assessment and treatment, with psychiatric care in-person and by eConsult.
   - Registry. A patient registry, of patients who are deemed to be at risk for depression or a substance abuse disorder will be established so they are provided with more in-depth assessments, continuity and targeted treatments.

- Treatment Plans. Single comprehensive treatment plans will be developed for patients with complex medical and mental health problems or high inpatient utilization. The plans will address the patient's behavioral, medical, substance abuse, social, cultural and linguistic needs.

We chose the collaborative care approach because it has been shown to promote quality, patient centered care and supports inter-professional directed treatments in the primary health setting in a cost-effective manner. Furthermore, this approach was selected to build on existing strengths at UCSDH, including a robust EHR, ehealth initiatives and the current co-location of mental health clinicians in multiple sites.

The first steps for sites with co-located mental health clinicians will be to add universal screening and establish a registry of patients who screen positive for depression or substance abuse disorders.

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

Target Population: Within the PRIME eligible population this project will focus on screening all patients 18 years or older seen in primary care settings and on improving the care for patients with known mental health issues or those who screen positive for depression or substance abuse. Access to embedded behavioral health providers is anticipated to increase access to care and coordination with medical health providers.

Vision for Care Delivery: PRIME will enable UCSDH to expand our efforts to integrate mental health treatment in our physical health care settings. By expanding universal screening from a few clinical sites to all primary care clinics and pairing this with a collaborative care model, we will increase the number of UCSDH patients who receive effective treatment for depression, anxiety, substance abuse and other common mental/behavioral health disorders. To ensure that these efforts keep the patient at the center of these efforts and consistent with UCSDH's current priority of improving the patient experience, we will utilize an advisory board that has substantial patient representation. Finally, utilizing this collaborative care approach, we anticipate significant cost savings. We hope to develop metrics to measure the cost savings that this integration brings to USCDH.

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

| Check, if applicable | Description of Core Components |
|---|---|
| **Not Applicable** | **1.1.1** Implement a behavioral health integration assessment tool (baseline and annual progress measurement) |
| **Applicable** | **1.1.2** Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration, the Collaborative Care Model, or other Integrated Behavioral Health (IBH) resources from SAMHSA) |
| **Not Applicable** | **1.1.3** Integrate appropriate screening tools and decision support into the emergency department (ED) to ensure timely recognition of patients with mental health and substance use disorder problems. Enhanced access to primary care and/or to behavioral health specialists will be integrated into discharge planning for these patents. Use of 24-7 care navigators (e.g., Community Physician Liaison Program) may be used to support linkages to primary care providers (PCPs), mental health (MH) and substance use disorder (SUD) specialists and behavioral health and other community services through the discharge process. |
| **Applicable** | **1.1.4** Integrate physical and behavioral health, either through implementation of a new program or an expansion of an existing program, from pilot sites to hospital and health system primary care sites or from single populations to multiple populations (e.g., obesity, diabetes, maternal, infant, and child care, end-of-life care, chronic pain management). |
| **Not Applicable** | **1.1.5** Patient-Centered Medical Home (PCMH) and behavioral health providers will:<br>• Collaborate on evidence based standards of care including medication management and care engagement processes.<br>• Implement case conferences/consults on patients with complex needs. |
| **Not Applicable** | **1.1.6** Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families. |
| **Applicable** | **1.1.7** Ensure systems are in place to support patient linkages to appropriate specialty physical, mental and SUD services. Preventive care screenings, including behavioral health screenings (e.g., PHQ-2, PHQ-9, SBIRT), will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate |

| Check, if applicable | Description of Core Components |
|---|---|
| | 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. |
| **Applicable** | **1.1.9** Increase access to Medication Assisted Treatment (MAT) for patients with alcohol and opioid addiction to assist in stabilizing their lives, reducing urges or cravings to use, and encourage greater adherence to treatment for co-morbid medical and behavioral health conditions. For alcohol use disorders these medications include naltrexone, acamprosate, and disulfiram. For opioid addiction, medication assisted treatment (MAT) includes maintenance treatment with methadone and buprenorphine. |
| **Applicable** | **1.1.10** Ensure the development of a single treatment plan that includes the patient's behavioral health issues, medical issues, substance abuse, social and cultural and linguistic needs. This includes incorporating traditional medical interventions, as well as non-traditional interventions such as gym memberships, nutrition monitoring, healthy lifestyle coaching, or access to culturally and linguistically appropriate peer-led wellness and symptom management groups. |
| **Not Applicable** | **1.1.11** Ensure a culturally and linguistically appropriate treatment plan by assigning peer providers or other frontline worker to the care team to assist with care navigation, treatment plan development and adherence. |
| **Applicable** | **1.1.12** Ensure that the treatment plan:<br>• 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.<br>• 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 |

| Check, if applicable | Description of Core Components |
|---|---|
| | 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:<br>• Implementing a model for team-based care in which staff performs to the best of their abilities and credentials.<br>• Providing ongoing staff training on care model. |
| **Applicable** | **1.1.16** Ensure integration is efficient and providing value to patients by implementing a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. |

## ☒ 1.2 Ambulatory Care Redesign: Primary Care (required for DPHs)

1. *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]*

Ambulatory re-design enhances UCSDH's commitment to care that is high value, patient centered, and community responsive. By focusing on patient-centered processes, patient experience, and community involvement, we aim to improve access, quality, and effectiveness of care for a diverse group of patients.

Our planned implementation will include:

- Patient Centered Medical Home (PCMH) Principles. UCSDH has established primary care programs in internal medicine, family medicine, geriatrics and HIV care. UCSDH's primary care programs provide care to approximately 65,000 individuals in San Diego County regardless of geographic location, insurance type or socio-economic strata. While two of our three Family Medicine clinics have received PCMH designation, all clinics are committed to core PCMH principles. We will implement PCMH qualification standards as a result of multiple PRIME activities at all of our primary care sites. Processes and procedures that align with NCQA guidance related to empanelment, team-based care, delivery, patient engagement, and quality improvement will be utilized. This will be done in partnership with staff, providers and administration in a manner similar to that used by our two qualified Family Medicine sites.

- Standardization. Protocols, care algorithms and techniques such as team huddles will be developed and utilized to support evidence based care. Health navigators will be added to all UCSDH primary care sites.

- Data. UCSDH expects to perform real time population health analytics that support patients, providers, and healthcare teams. Leveraging the electronic health record (EHR), population based data and measurement tools will be developed and implemented. A data driven and outcomes focused approach will enables innovation in the provision of improved medical services.

- Engagement. Enhancements to pre-clinic planning, bi-directional electronic communication between patient and providers, and telehealth services are planned. Telehealth and the patient web portal will facilitate patient engagement. Alternatives to face-to-face visits and electronic patient-driven appointment scheduling are expected to improve access and care.

Physician and team-level population health reports are expected to drive high value care. Physicians, nurses, staff, patients and administration will be engaged in the design and implementation. The approach will be collaborative and team-based, leveraging existing quality and data management infrastructure. Progress will be monitored through various quality committees with oversight by medical and hospital leadership.

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

Target population: Because of the comprehensive nature of this project, which includes process redesign, infrastructure builds, data driven quality improvement efforts and reductions in variation and disparities, we anticipate this project impacting the entire PRIME eligible population.

Vision for Care Delivery: Currently, established protocols and registry driven evidence-based preventive and chronic disease management lack optimization of workflow, coordination, and standardization. UCSDH aims to 1) improve services to the underserved 2) address health disparities and 3) support community needs. In order to address health disparities and support service delivery to the underserved, this project will closely integrate with behavioral health (Project 4.1.1) and care management (Project 4.2.3). Given that type 2 diabetes, cardiovascular disease, and mental health are significant health concerns for San Diego County; UCSDH expects this project to impact local needs. UCSDH expects to measurably improve upon the baseline performance in the areas of preventive screening for cancer, behavioral health and substance abuse, diabetes, cardiovascular disease, and patient experience. As a result of improved access, care delivery and coordination, UCSDH expects improvements in avoidable utilization of emergency department visits and hospitalizations. Through improved visibility of REAL/SO/GI reporting of health disparities, UCSDH expects to identify care gaps and develop new processes to reduce disparities in care.

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

| Check, if applicable | Description of Core Components |
|---|---|
| **Not Applicable** | **1.2.1** Conduct a gap analysis of practice sites within the DPH/DMPH system. |
| **Not Applicable** | **1.2.2** Primary care practices will demonstrate advancement of their PCMH transformation through the use of a nationally-recognized PCMH methodology. |
| **Not Applicable** | **1.2.3** Hiring and training of frontline workforce (e.g., medical assistants, community health workers, promotoras, health navigators or other non-licensed members of the care team) to be responsible for coordination of non-clinical services and elements of the care plan. |
| **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.<br>• Implementation of EHR technology that meets meaningful use (MU) standards. |
| **Not Applicable** | **1.2.5** Ongoing identification of all patients for population management (including assigned managed care lives):<br>• Manage panel size, assignments, and continuity to internal targets.<br>• Develop interventions for targeted patients by condition, risk, and self-management status.<br>• Perform preventive care services including mental health and substance misuse screenings and brief interventions (e.g., PHQ-9, SBIRT). |
| **Applicable** | **1.2.6** Enable prompt access to care by:<br>• Implementing open or advanced access scheduling.<br>• Creating alternatives to face-to-face provider/patient visits.<br>Assigning frontline workers to assist with care navigation and non-clinical elements of the care plan. |
| **Not Applicable** | **1.2.7** Coordinate care across settings:<br>• Identification of care coordinators at each primary care site who are responsible for coordinating care within the PCMH as well as |

| Check, if applicable | Description of Core Components |
|---|---|
| | with other facilities (e.g., other care coordinators or PCMH/DPH/DMPH high risk care managers):<br>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<br>Implement processes for timely bi-directional communication and referral to specialty care (including mental health and substance use disorder services), acute care, social services and community-based services. |
| **Applicable** | **1.2.8** Demonstrate evidence-based preventive and chronic disease management. |
| **Not Applicable** | **1.2.9** Improve staff engagement by:<br>• Implementing a model for team-based care in which staff performs to the best of their abilities and credentials.<br>• Providing ongoing staff training on the team-based care model to ensure effective and efficient provision of services (e.g., group visits, medication reconciliation, motivational interviewing, cognitive behavioral therapy and Medication-Assistance Treatment (MAT)). |
| **Not Applicable** | **1.2.10** Engage patients using care plans, and self-management education, and through involvement in the design and implementation of this project. |
| **Applicable** | **1.2.11** Improve the accuracy and completeness of race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI) data, and use that data to identify and reduce disparities in one or more Primary Care Redesign project metrics by:<br>• 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.<br>• Developing capacity to track and report REAL/SO/GI data, and data field completeness.<br>• Implementing and/or refining processes for ongoing validation of REAL/SO/GI data.<br>• Developing capacity to stratify performance metrics by REAL/SO/GI data and use stratified performance data to identify disparities for targeted interventions. |

| Check, if applicable | Description of Core Components |
|---|---|
| | • Developing capacity to plan and implement disparity reduction interventions with input from patients and community stakeholders.<br>• Developing dashboards to share stratified performance measures with front-line staff, providers, and senior leadership. |
| **Not Applicable** | **1.2.12** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. |

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

1. *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]*

   Redesign of Specialty Care will enhance and improve the services provided to our patients across all ambulatory sites throughout the care continuum by 1) protocol standardization 2) improved access and 3) high value care delivery.

   Our planned implementation will include:

   - Standardization. Development of treatment protocols implemented and tracked in specialty areas with a goal to use the same specialty relevant protocol regardless of location. Specialty protocols will include but not be limited to reproductive medicine, urology, cardiology, gastroenterology, oncology and orthopedics.

   - Medication adherence. By integrating pharmacy expertise into the ambulatory specialty clinical settings through EHR based medication reconciliation tools and direct access to pharmacists for select populations, compliance with care plans will be improved.

   - Technology: UCSDH's integrated EHR, registries, protocol driven patient reminders, patient call lists, and embedded protocols which improve access and coordination will be spread into specialty services.

   - Communication. UCSDH will leverage existing systems and best practices to develop standardized workflows and communication paths between primary and specialty providers, as well as referring physicians outside of UCSDH. UCSDH's recently implemented eConsult system within the EHR facilitates primary care physicians' communication to specialty providers that is structured and timely. Measurement and reporting of eConsult activity will be expanded. Telehealth capabilities will include both eConsult and video visits between primary care and specialty providers to enable timely access to specialty care. UCSDH's EHR functionality to "communication-manager" enables specialty physicians to communicate consult results with referring physicians using closed loop processes.

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

Target Population: Because of the comprehensive nature of this project, which includes enhanced access to specialty support, process redesign, infrastructure builds, data driven quality improvement efforts and reductions in variation and disparities, we anticipate this project will impact the PRIME eligible population requiring UCSDH specialty care expertise.

Vision for Care Delivery: The Ambulatory Re-design of Specialty Care components were selected to improve the patient experience and clinical outcomes by improving communication between providers, and between providers and patients, as well as improved medication adherence. Through UCSDH's adoption of standardized protocols, improved communication, and novel access, UCSDH aims to standardize care, decrease variation and drive better clinical outcomes. We aim to enhance population health management tools for disease prevention and chronic disease management that enable patients, specialists, care teams, and the primary care provider to pro-actively identify needed preventive and chronic care needs. Through expanded telehealth services including eConsults between primary care and specialty care as well as the store-forward telemedicine in specialties such as dermatology, UCSDH expects to enhance specialty care eConsult uptake, access and appropriate utilization. Progress will be measured by reductions in emergency visits and readmissions, and improved communication amongst providers.

*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. |
| **Not Applicable** | **1.3.6** Establish processes to enable timely follow up for specialty expertise requests. |
| **Applicable** | **1.3.7** Develop closed loop processes to ensure all requests are addressed and if in person visits are performed, that the outcome is communicated back to the PCP. |
| **Applicable** | **1.3.8** Ensure that clinical teams engage in team- and evidence-based care. |
| **Not Applicable** | **1.3.9** Increase staff engagement by:<br>• Implementing a model for team-based care in which staff performs to the best of their abilities and credentials.<br>• Providing ongoing staff training on the care model. |
| **Applicable** | **1.3.10** Develop and implement standardized workflows for diversified care delivery strategies (e.g., shared medical visits, ancillary led services, population management, telemedicine services) to expand access and improve cost efficiency. |
| **Applicable** | **1.3.11** Adopt and follow treatment protocols mutually agreed upon across the delivery system. |
| **Not Applicable** | **1.3.12** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population management activities and care coordination/transitions of care. Ensure that timely, relevant, and actionable data are used to support patient engagement, PCP collaboration, and drive clinical, operational and strategic decisions including continuous quality improvement (QI) activities. |
| **Not Applicable** | **1.3.13** Implement EHR technology that meets MU standards. |
| **Not Applicable** | **1.3.14** Patients have care plans and are engaged in their care. Patients with chronic disease (including MH/SUD conditions) managed by |

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

## ☒ 1.5 – Million Hearts Initiative

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]*

   UCSDH's rationale for selecting the Million Hearts initiative is because cardiovascular disease is a leading cause of death in San Diego County and across the state of California. Cardiovascular disease disproportionately affects SD County with a rising incidence (refer to PRIME 2.1). With local expertise afforded through a world-class cardiovascular center, UCSDH aims to enhance development of prevention opportunities specific to cardiovascular disease.

   Our planned implementation will include:

   - Standardization. The approach will be adherence to evidence-based measures through protocols (PRIME 4.1.2) developed based on recommendations by the United States Preventive Services Task Force (USPSTF). Population health tools within the EHR will be utilized to identify patients for cardiovascular risk screening and intervention.

   - Engagement. Patient engagement through care management (PRIME 4.2.3), the patient web portal, and enhanced access (PRIME 4.2.2) will deliver risk reduction. Staff and providers will be engaged at all levels of the change process including the design and implementation of care pathways, communication tools and intervention strategies. We will place an extra emphasis on patients with diabetes because of their special vulnerability.

   - Data. Performance targets will include blood pressure measurement and control as well as lipid measurement and control. UCSDH will enhance continuous staff training to assure that blood pressure is measured properly at all appropriate ambulatory visits.

   - Community. Through collaboration with community links to resources for cardiovascular health such as the San Diego County Health Department, federally qualified health clinic (FQHCs) and other organizations, UCSDH will aim to develop health messages and health education that are culturally appropriate and community responsive. In addition, UCSDH will strengthen the relationships with local organizations in order to facilitate referral to community preventive resources.

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

Target population: This project aims to better facilitate primary, secondary and tertiary prevention of cardiovascular disease for all patients in the PRIME eligible population, including those with and without diabetes. We anticipate these changes will impact other patients with cardiovascular disease for whom we provide care.

Vision for Care Delivery: Using population health tools and registries (primary care, diabetes and cardiovascular) we will be able to identify and target patients for age and disease specific screening that facilitates improved health outcomes.

Patient self-management will be driven through access to personal health information in the patient web portal in English and Spanish as well as support via case management and health navigation. Through enhanced engagement and care coordination, UCSDH expects to drive better awareness and outcomes. The use of care navigators (PRIME 4.1.2), who will also serve as peer educators, is believed to result in improve health awareness and adherence to healthy diet and exercise programs.

Performance metrics will include improvements in blood pressure and use of anti-platelet agents in patients with ischemic vascular disease, as well as screening for and counseling of patients who use tobacco products. Ultimately, this project aims to drive value through decreased risk and rates of cardiovascular events.

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

| Check, if applicable | Description of Core Components |
|---|---|
| **Not 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. |
| **Not Applicable** | **1.5.4** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health. |

| Check, if applicable | Description of Core Components |
|---|---|
| **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. |
| **Not Applicable** | **1.5.7** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.<br>• Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts. |
| **Not Applicable** | **1.5.8** Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs. |

***Please complete the summary chart:***

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

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

### ☒ 2.1 – Improved Perinatal Care (required for DPHs)

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]*

   UCSDH believes ensuring a healthy pregnancy, delivery and beginning of life are key to a healthy population. As an academic safety net hospital, we provide a full spectrum of perinatal care from a unique in-hospital birthing center staffed by midwives for low risk pregnancies to a high-risk service for the most complex obstetrical cases supported by perinatologists and neonatologists.

   Our planned implementation will include:

   - Collaboration. UCSDH actively participates in the California Partnership for Maternal Safety/Patient Safety First (CPMS/PSF) collaborative whose primary focus is decreasing maternal morbidity and mortality related to obstetrical hemorrhage and severe preeclampsia. Our post-partum hemorrhage rate has improved over the past 4 years through better documentation and implementation of most of the elements of the California Maternal Quality Care Collaborative (CMQCC) obstetrical hemorrhage bundle. During PRIME, we will focus on formalizing our multidisciplinary review of significant events to identify improvement opportunities, as well as creating a support program for patients, families and staff.

   - Standardization. Although UCSDH has a relatively low cesarean section rate, we have opportunities for improvement. We are adopting the ACOG guidelines for reducing the risk of cesarean section. Our institution will be participating in a new CMQCC collaborative to further decrease the rate of primary cesarean section. To ensure women receive timely postpartum care, we plan to implement a new scheduling process to improve access.

   - Data. We are currently tracking and reporting many of the PRIME process and outcome metrics, but have not included prenatal and postpartum care. We will monitor these measures during monthly OB Quality and Perinatal Practice meetings and pursue improvement opportunities.

   - Engagement. UCSDH is currently one of only four hospitals in San Diego and Imperial counties designated as Baby-Friendly facility by UNICEF and WHO. We have been reporting Exclusive Breastmilk Feeding results to the Joint Commission with favorable performance; breastfeeding for

women and their infants will remain a priority. New breastfeeding projects that we plan to undertake include: (1) ongoing annual quality improvement projects linked to and determined by Baby Friendly USA, (2) implementation of early oral colostrum administration in very low birth weight infants in the NICU, (3) expansion of donor breastmilk use in the late preterm infants and (4) implementation of bar code scanning of milk on the postpartum unit.

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

Target Population: Through improvements in prenatal and postnatal care, reductions in intrapartum morbidity and mortality, and support for breastfeeding of infants born at all gestational ages, the health of mothers and infants in the PRIME eligible population, as well as all mothers and infants receiving care at UCSDH, will be improved.

Vision for Care Delivery: Participation in PRIME will enable UCSDH to accomplish several key objectives that are central to our ability to provide high-quality, patient centered perinatal care. Improving breastmilk feeding above our current rates will further improve the short-term and long-term medical and neurodevelopmental health of our babies. The HEDIS Postpartum Care measure set, which will track whether patients have a postpartum visit scheduled prior to discharge and documentation that appropriate care is provided at the postpartum visit, is a new initiative for UCSDH and should improve care for our mothers in their postpartum transition. Continued participation in CPMS/PSF collaborative will reduce the incidence of severe post-partum hemorrhage and complications of severe hypertension, a leading cause of maternal mortality and morbidity. Closely monitoring our cesarean section rate and pursing improvement opportunities will help reduce post-surgical infections and other complications, as well as improving overall health outcomes for both mother and baby.

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

| Check, if applicable | Description of Core Components |
|---|---|
| **Applicable** | **2.1.1** DPHs/DMPHs engagement in best practice learning collaborative to decrease maternal morbidity and mortality related to obstetrical hemorrhage (CMQCC/PSF/HQI combined effort). |
| **Applicable** | **2.1.2** Achieve baby-friendly hospital designation through supporting exclusive breastfeeding prenatally, after delivery, and for 6 months after delivery and using lactation consultants after delivery. |

| 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)

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]*

   UCSDH believes the quality of care transitions significantly affects the safety and effectiveness of the care delivered across our own organization, as well as the care of community providers to whom we discharge some of our patients. We have taken steps to improve transitions for patients at the highest risk for readmission and now look to extend these efforts to more patients. Better transitions will also improve the satisfaction of our patients and referring providers.

   Our planned implementation will include:

   - Medication reconciliation. UCSDH will improve the completeness and reliability of the medication reconciliation process for hospitalized patients. We will define the specific responsibilities for the different team members, including nurses, case managers, pharmacy technicians, pharmacists and physicians. Using process maps, we will identify ways to support the medication reconciliation process with functionality in the electronic health record and will define measures to assess our progress.

   - Medical Homes. We will extend our efforts to accurately identify our patient's primary providers and for patients without a primary care provider, we will work with them to connect to a suitable medical home. We will develop processes to finalize specific follow-up appointment times prior to discharge and to transmit transition records to patients' next providers at their first post-hospitalization appointments. We expect to work on this during years 1 through 3.

- Readmission Reduction. We will evaluate our current methods for assessing the readmission risk for our patients. We will investigate additional approaches to improve readmission risk assessments through better use of available electronic data, allowing us to have electronic health record-based readmission risk scoring tools. We expect this work to occur in years 2 and 3. Having better defined risks for readmission we will develop targeted intervention to reduce risks of readmission.

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

Target Population: Improvements in medication reconciliation and targeted interventions to reduce readmission will impact patients in the PRIME eligible population who experience hospitalization in acute care facilities. Our medication reconciliation efforts will be focused on patients with high-risk medication lists prior to admission or at the time of discharge. Our medication risk score includes medications with high-risk profiles (e.g., anticoagulants, oral hypoglycemic, anticonvulsants, etc.) and the total number of medication. We will also implement a readmission risk scoring system (e.g., LACE score or similar) using electronic clinical data to identify those at high risk for readmission. Due to the systemization of these interventions, we anticipate other patients discharged from our acute care facilities will also benefit.

Vision for Care Delivery: This section of our PRIME transition of care efforts will improve our organization's ability to ensure reliable communication and high quality care as patients are discharged from our inpatient settings. Our efforts will reduce the unintended negative consequences of handoffs of patient care through accurate documentation and communication of medication regimens and targeted interventions to maximize the likelihood that high-risk patients have a successful transition to the post-acute setting. These efforts will also help to close the gap between the follow-up care that is intended and the care that is actually received. By ensuring timely and appropriate follow-up appointments with providers who are well informed of what care has been provided and what additional care should be considered, we will support a system that leaves our patients confident that our organization is working as a coordinated team to optimize their health.

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

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

| Check, if applicable | Description of Core Components |
|---|---|
| **Applicable** | **2.2.6** Develop standardized workflows for post-discharge (outpatient) care:<br>• Deliver timely access to primary and/or specialty care following a hospitalization.<br>• Standardize post-hospital visits and include outpatient medication reconciliation. |
| **Not Applicable** | **2.2.7** Support patients and family caregivers in becoming more comfortable, competent and confident in self-management skills required after an acute hospitalization by providing:<br>• Engagement of patients in the care planning process.<br>• Pre-discharge patient and caregiver education and coaching.<br>• Written transition care plan for patient and caregiver.<br>• Timely communication and coordination with receiving practitioner.<br>Community-based support for the patient and caregiver post hospitalization focusing on self-care requirements and follow-up care with primary and specialty care providers. |
| **Not Applicable** | **2.2.8** Engage with local health plans to develop transition of care protocols that ensure: coordination of care across physical health, substance use disorder and mental health spectrum will be supported; identification of and follow-up engagement with PCP is established; covered services including durable medical equipment (DME) will be readily available; and, a payment strategy for the transition of care services is in place. |
| **Not Applicable** | **2.2.9** Demonstrate engagement of patients in the design and implementation of the project. |
| **Not Applicable** | **2.2.10** Increase multidisciplinary team engagement by:<br>• Implementing a model for team-based care in which staff performs to the best of their abilities and credentials.<br>• Providing ongoing staff training on care model. |
| **Not Applicable** | **2.2.11** Implement a system for continual performance feedback and rapid cycle improvement that uses standard process improvement methodology and that includes patients, front line staff and senior leadership. |

## ☒ 2.3 – Complex Care Management for High Risk Medical Populations **(required for DPHs)**

1. *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]*

   UCSDH provides care to all patients, but has particular expertise in caring for higher acuity, sicker patients. Patients often have cardiovascular disease, diabetes and cancer either acutely or as part of their medical history. UCSDH seeks to provide seamless care services through the continuum of care, from ambulatory to acute, and across primary care and specialty care. Using the complex care methodology outlined and validated by the California Quality Collaborative, UCSDH aims to develop complex care management for our target PRIME population.

   Our planned implementation will include:

   - Care Management Redesign. UCSDH recently initiated a re-organization of our care management structure that will affect and improve the manner in which transitions for our patients through the continuum of acute, post-acute and ambulatory care services are provided. Navigators (PRIME 4.1.2) will be used to help improve access, utilization, and adherence. Through team building, UCSDH aims to develop expertise in care managers that is responsive to patient demographics in key critical areas such as cardiology, oncology, pulmonary, HIV, orthopedics and mental health. Due to the complexity and diversity of the constellation of illness, UCSDH will aim to develop an array of disease specific skill sets for care management. In addition, care management will enhance empanelment to a primary care provider and continuity of care.

   - Risk Stratification. As part of our strategy, we aim to adopt a risk stratification strategy to assure that patients at the highest risk of emergency room visits, hospital admissions and readmissions are tiered to the appropriate intensity of care management oversight. Pharmacists will be assigned to patients with complex medical regiments or high risk medication profiles to assist with medication education, reconciliation and adherence UCSDH internal risk acuity tool utilized to assess risk of readmission will be reexamined and modified as appropriate.

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

Target Population: Restructuring and enhancement of our care coordination efforts, with a focus on medically complex patients, will improve the experience and clinical outcomes for patients within the PRIME eligible population, age 18 and over, with 4 or more chronic medical conditions. We anticipate these efforts will spread beyond the PRIME population, resulting in fewer readmissions, emergency and urgent care visits.

Vision for Care Delivery: By developing a system of care that stratifies patients using determinants such as age, number of medical problems, frequency of emergency department and hospital visits, number and types of medications, and social supports, UCSDH aims to develop a system that better serves patients and leverages resources. By engaging staff, providers and patients in the process of developing this care model, UCSDH aims to infuse knowledge about providing care in a way that is contemporary, truly team-based, and multi-disciplinary.

One of the desired outcomes of PRIME complex care management will be that patients receive the right care, at the right time, by the right level of staff for their medical condition. Care management will enhance access to alternative sites of care in the community such as the patient's home, sub-acute and acute care facilities.

Our ultimate project goal is to provide patients with a better experience and better health utilization and better outcomes as measured by fewer emergency room visits, hospitalizations, and re-admissions. UCSDH will institute assignment of high-risk case managers, perform medication reconciliation (pre and post hospitalization) and assure the timely transmission of medical records.

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

| Check, if applicable | Description of Core Components |
|---|---|
| **Not Applicable** | **2.3.1** Develop a complex care management program at one site or with one defined cohort, or expand an existing program from a pilot site to all sites or to additional high-risk groups and demonstrate engagement of patients in the design and implementation of the project. |
| **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. |
| **Not Applicable** | **2.3.5** Establish data analytics systems using clinical data sources (e.g., EHR, registries), utilization and other available data (e.g., financial, health plan, zip codes), to enable identification of high-risk/rising risk patients for targeted complex care management interventions, including ability to stratify impact by race, ethnicity and language. |
| **Applicable** | **2.3.6** Develop a multi-disciplinary care team, to which each participant is assigned, that is tailored to the target population and whose interventions are tiered according to patient level of risk. |
| **Not Applicable** | **2.3.7** Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets. |

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

## ☒ 2.7 – Comprehensive Advanced Illness Planning and Care

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]*

UCSDH has devoted extensive efforts to expand the size and effectiveness of our palliative care consult services in recent years and as a result palliative care consults have increased over 240% in the past five years. But it is clear that current efforts are not addressing the needs of many of our patients. To ensure that all patients receive excellent palliative care, front line clinicians will need additional skills and the palliative care team will need expansion.

Our planned implementation will include:

- Palliative care curriculum. A palliative care curriculum for those who see patients with advanced cancer, heart disease, COPD, cirrhosis, renal disease, and neurodegenerative disorders will be implemented. Training will focus on communication, symptom management, and care coordination and planning. The goal is to improve the quality of care provided to seriously ill people by increasing the skill set of providers and expanding efforts to reach patients early in the course of their illness, long before they are at the end of life.

- Data. To guide processes and improve patient-level outcomes, dashboards for palliative care and advanced illness will be designed. Data on individual providers with peer, institutional and national benchmark comparisons will be generated. Data will be used for institutional and individual performance improvement.

- Advanced care planning. Processes and mechanisms to better understand and capture our patient's goals of care and advanced directive wishes within our electronic health record will be developed.

- Expansion. The capacity and expertise of our palliative care team will be enhanced by the addition of chaplain support to the existing team of physicians, nurses, pharmacists and social workers.

Care will be consistent with emerging standards of care, be guided by data, occur early and throughout the course of illness, and be consistent with patients' priorities; this will greatly enhance the quality of care at UCSDH.

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

Target Population: PRIME eligible patients who have stage 4 cancer or with advanced end organ failure (any of the following: ESRD in pts > 80 yo, ESLD (MELD Score ≥30), Class IV CHF, Stage IV COPD, Advanced dementia (CDR 3), or Neurodegenerative disease who are non-ambulatory) will benefit from better advanced care planning and palliative care support; these efforts will also impact other patients with advanced illness receiving care at UCSDH.

Vision for Care Delivery: Our goal is to support all patients with advanced, symptomatic disease that may benefit from palliative care, through palliative care training of frontline providers, better understanding of our patients wishes for end of life care, enhanced spiritual care, support early in the course of illness and data monitoring to drive ongoing improvement efforts.

When front line providers better understand the principles and practices of palliative care, we believe they will be more likely to communicate with patients and families effectively, manage symptoms expertly, design care plans that match patient wishes, engage specialist palliative care more often, and enlist hospice services earlier. When they have detailed outcomes data to guide them they will be even more effective.

Simple and user-friendly means of advance care planning are more likely to be effective at identifying patients' goals. Documenting those goals in an accessible and standardized way in the electronic health record will increase the chances that those wishes are known and followed.

Providing whole-person care, including effective psychosocial and spiritual care, significantly increases patient satisfaction, reduces suffering, and decreases provision of futile interventions.

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

| Check, if applicable | Description of Core Components |
|---|---|
| **Applicable** | **2.7.1** Establish or expand both ambulatory and inpatient palliative care (PC) programs that provide:<br>• Total, active and individualized patient care, including comprehensive assessment, inter-professional care planning and care delivery.<br>• Support for the family.<br>• Interdisciplinary teamwork.<br>• Effective communication (culturally and linguistically appropriate).<br>• Effective coordination.<br>• Attention to quality of life and reduction of symptom burden.<br>• Engagement of patients and families in the design and implementation of the program. |
| **Applicable** | **2.7.2** Develop criteria for program inclusion based on quantitative and qualitative data:<br>• Establish data analytics systems to capture program inclusion criteria data elements. |
| **Applicable** | **2.7.3** Implement, expand, or link with, a Primary Palliative Care training program for front-line clinicians to receive basic PC training, including advanced care planning, as well as supervision from specialty PC clinicians.<br>Assure key palliative care competencies for primary care providers by mandating a minimum of 8 hours of training for front line clinicians in communication skills and symptom management. |
| **Applicable** | **2.7.4** Develop comprehensive advance care planning processes and improve implementation of advance care planning with advanced illness patients. |
| **Applicable** | **2.7.5** Establish care goals consistent with patient and family preferences, and develop protocols for management/control of pain and other symptoms in patients with advanced illness, including a holistic approach that includes spiritual and emotional needs. |
| **Not Applicable** | **2.7.6** Improve completion of Physician Orders for Life-Sustaining Treatment (POLST) with eligible patients and participate in the state-wide POLST registry. |
| **Not Applicable** | **2.7.7** Provide access to clinical psychologist on the palliative care team to address psychological needs of patient and the family members during the |

| Check, if applicable | Description of Core Components |
|---|---|
| | advanced illness and provide grief counseling and support to the family after death of their loved ones. |
| **Not Applicable** | **2.7.8** Enable concurrent access to hospice and curative-intent treatment, including coordination between the providing services. |
| **Applicable** | **2.7.9** Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice, including linkage with PC training program. |
| **Not Applicable** | **2.7.10** For advanced illness patients transitioning between primary care, hospital, skilled nursing facilities (SNFs), and/or home-based environments, ensure that the advance care plan is clearly documented in the medical record and transmitted in a timely manner to the receiving facilities and care partners who do not have access to the health system's medical record. |
| **Applicable** | **2.7.11** Engage staff in trainings to increase role-appropriate competence in palliative care skills, with an emphasis on communication skills. |
| **Applicable** | **2.7.12** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. |

***Please complete the summary chart:***

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

## Section 4.3 – Domain 3: Resource Utilization Efficiency

### ☒ 3.1 – Antibiotic Stewardship

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]*

The development of antibiotics changed the practice of medicine by providing treatments against lethal bacteria. The overdependence on antibiotics, however, has given rise to the emergence of bacteria resistant to antibiotics and has facilitated the spread of opportunistic pathogens such as Clostridium difficile. Research suggests that 20-50% of antibiotics prescribed in acute healthcare in the US may be unnecessary or inappropriate. UCSDH selected this project with the goal of reducing adverse events related to antibiotic use and antibiotic resistance. California legislation (SB 1311) mandates "general acute care hospitals to adopt and implement… an antimicrobial stewardship policy… that includes a process to evaluate the judicious use of antibiotics".

Our planned implementation will include:

- Antibiotic Stewardship Program (ASP). UCSDH's ASP, co-led by pharmacists and Infectious Diseases physicians, will collaborate with microbiologists, informatics personnel, hospitalists, the epidemiology and infection prevention team, and others to improve antimicrobial use. The committee will meet at least every other month to develop and promote policies and projects that will improve antibiotic-related clinical use including certain PRIME core components.

- Standardization. Clinical decision support algorithms which promote antibiotic stewardship through improved diagnostics, appropriate antibiotic selection, dosing and de-escalation will be built into workflows and the electronic health record.

- Monitoring. UCSDH's ASP will expand to monitoring system-wide antibiotic use and optimize the ability to identify clinical areas where greater stewardship efforts are needed.

- Diagnostic Tools. Working with the expert microbiologists running UCSDH's diagnostic microbiology laboratory, we will continue to introduce and utilize the most clinically relevant, cost-effective, and rapid diagnostics to improve the use of diagnostic tools to help distinguish viral vs. bacterial infections, and resistant vs. sensitive organisms.

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

Target Population: Effective use of antibiotics, and other antimicrobials, will impact the PRIME eligible population and all hospitalized patients requiring antibiotic or antimicrobial treatment at UCSDH. These efforts will help reduce the spread of multi-drug resistant organisms and promote appropriate therapeutic interventions.

Vision for Care Delivery: Antibiotics are a unique medication in that they not only affect the person receiving the drug, but also potentially have an effect on the general patient population by contributing to resistant microbes that populate healthcare environments. Several studies have shown that ASPs can 1) improve clinical outcomes related to antibiotic use 2) minimize toxicity and other adverse events 3) reduce the costs of healthcare for infections and 4) limit the development of bacterial strains resistant to first line antibiotics. Broadened antibiotic stewardship efforts at UCSDH will thus benefit all patients. In addition, UCSDH treats patients who are highly susceptible to bacterial infections, such as bone marrow, solid organ transplant recipients and AIDS patients. Thus, broadened antibiotic stewardship will help these particularly vulnerable populations as well as general inpatients and outpatients.

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

| Check, if applicable | Description of Core Components |
|---|---|
| **Applicable** | **3.1.1** Utilize state and/or national resources to develop and implement an antibiotic stewardship program, such as the California Antimicrobial Stewardship Program Initiative, or the IHI-CDC 2012 Update "Antibiotic Stewardship Driver Diagram and Change Package.[1]<br>• Demonstrate engagement of patients in the design and implementation of the project. |
| **Applicable** | **3.1.2** Develop antimicrobial stewardship policies and procedures. |

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

| Check, if applicable | Description of Core Components |
|---|---|
| **Applicable** | **3.1.3** Participate in a learning collaborative or other program to share learnings, such as the “Spotlight on Antimicrobial Stewardship" programs offered by the California Antimicrobial Stewardship Program Initiative.[2] |
| **Applicable** | **3.1.4** Create standardized protocols for ordering and obtaining cultures and other diagnostic tests prior to initiating antibiotics. |
| **Applicable** | **3.1.5** Develop a method for informing clinicians about unnecessary combinations of antibiotics. |
| **Applicable** | **3.1.6** Based on published evidence, reduce total antimicrobial Days of Therapy (DOT) by providing standards and algorithms for recommended agents by disease type, focusing on short course regimens (e.g., 3-5 days of therapy for uncomplicated cystitis, 7 days for uncomplicated pyelonephritis, 5-7 days for uncomplicated non-diabetic cellulitis, 5-day therapy for community acquired pneumonia (CAP), 7-8 days for therapy for VAP or hospital acquired pneumonia). |
| **Applicable** | **3.1.7** Develop evidence-based computerized provider order entry (CPOE) algorithms and associated clinician training, to support antibiotic stewardship choices during order entry. These could include approaches such as guidelines for duration of antibiotics, within drug class auto-switching for specific antibiotics and doses, or restriction of specific antibiotics at the point of ordering (e.g., broad spectrum agents). |
| **Not Applicable** | **3.1.8** Implement stewardship rounds focusing on high yield drugs to promote de-escalation after the drugs are started, such as regular antibiotic rounds in the ICU. |
| **Not Applicable** | **3.1.9** Improve diagnostic and de-escalation processes to reduce unnecessary antibiotic use based upon length of therapy or antibiotic spectrum, such as:<br>• Procalcitonin as an antibiotic decision aid.<br>• Timely step-down to oral antibiotic therapy to support early discharge from the hospital for acute infections.<br>• Use of oral antibiotics for osteomyelitis to reduce prolonged IV exposures. |
| **Applicable** | **3.1.10** Evaluate the use of new diagnostic technologies for rapid delineation between viral and bacterial causes of common infections. |

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

| Check, if applicable | Description of Core Components |
|---|---|
| **Not Applicable** | **3.1.11** Adopt the recently described "public commitment" strategy in outpatient clinics to encourage providers not to prescribe antibiotics for upper respiratory tract infections (URIs). |
| **Not Applicable** | **3.1.12** Publish organization-wide provider level antibiotic prescribing dashboards with comparison to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems. |
| **Not Applicable** | **3.1.13** Implement a system a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. |

## ☒ 3.3 – Resource Stewardship: Therapies Involving High Cost Pharmaceuticals

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]*

   UCSDH selected this project because it is consistent with our global objective to optimize value in medication use.

   Our planned implementation will include:

   - Standardization. Our existing EHR based medication ordering system, computer physician order entry (CPOE) has been used to design and implement drug ordering pathways. The Clinical Applications Team at UCSDH has experience developing sophisticated solutions within the fully deployed EHR. Currently, a limited group of ultra-high cost oncology medications require a review and sign-off process prior to initiation of therapy resulting in consistency in clinical care. This approach can be applied to other high cost pharmaceuticals, including antimicrobials.

   - Formulary Review. A list of the top drugs (by purchase expense) has already been created for the most recent fiscal year. It has identified some preliminary targets for which protocol based ordering may standardize use, consistent with clinical evidence. The first phase of this project will include formal review on high cost drugs or drug categories with potential for more appropriate drug use or alternative agents. The initial formulary review of high-cost drugs will be conducted by the

Pharmacy Department procurement team and Pharmacoeconomics & Outcomes Specialist. That review and analysis will be evaluated and enhanced by the project's physician coordinator. Through Vizient Inc. (a healthcare purchasing consortium), UCSDH has access to a comparative database from 143 US health care institutions with drug use reports which help to identify opportunities at a DRG and service specific level. An analogous reporting system for multiple University of California Health campuses will be developed. The reporting for both internal and trans-UC programs will be developed in collaboration with the UC San Diego Enterprise Reporting Team, who have experience with similar projects.

- Data. Working with new and existing data in the EHR we will develop specific reporting tools, including provider specific information on use of high cost drugs, compliance with the finalized protocols and patient outcomes, and dashboards showing medication use variation in high cost drug categories.

Key to this project is the development of clinical teams to design protocols and monitor use for targets within the high cost drug list.

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

Target Population: The effective use of high cost pharmaceuticals will impact the PRIME eligible population and all patients hospitalized at UCSDH. As a safety net hospital, managing the costs for pharmaceuticals while maintaining or improving outcomes, releases resources which can be redirected to others in need of care. During the initial years, our proposed project will focus efforts on the population of hospitalized patients in our organization. Over the course of PRIME, the impact on ambulatory patients will also be assessed and managed with similar strategies.

Vision for Care Delivery: Efforts to reduce drug waste, and reduce drug costs through formulary management have yielded important successes for us over the last several years. An important opportunity for the future will be to look at improvements in how and when specific high cost pharmaceuticals are introduced into clinical care. Standardization of the ordering of identified high-cost drugs should improve selection of high cost drugs to most evidence based population. This is also expected to reduce variation in use, clarify standards for appropriateness, and decrease costs for many of the target drugs. Optimal value is expected by minimizing variability between prescribers and providing tools which facilitate provider’s access to evidenced based protocols. This should lead to improved outcomes and reduce costs of care. The approach to improve use of high cost medications will be based upon application of evidence-based

principles, development of ordering criteria and protocols for the target drug. Annual reviews of the high costs drugs will be undertaken throughout PRIME.

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

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

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

***Please complete the summary chart:***

| | For DPHs | For DMPHs |
|---|---|---|
| Domain 3 Subtotal # of Selected Projects (Select At Least 1): | **2** | |
| Domain 3 Total # of Projects: | **2** | |

## 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 $ 35,043,400.00
- DY 12 $ 35,043,400.00
- DY 13 $ 35,043,400.00
- DY 14 $ 31,539,060.00
- DY 15 $ 26,808,201.00

**Total 5-year prime plan incentive amount: $** 163,477,461.00

## Section 9: Health Plan Contract (DPHs Only)

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

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

## Section 10: Certification

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