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   UCSF Health

Health Care System Designation(DPH or DMPH)   DPH

Section 2: Organizational and Community Landscape

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

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

Key findings from a 2012 Community Health Status Assessment commissioned by the San Francisco Department of Public Health reveal the following health care concerns and needs of the San Francisco Community:

- Over the next two decades, it is estimated that 55 percent of San Franciscans will be over the age of 45, and the population over age 75 will increase from 7 percent to 11 percent by 2030. This has implications for the need for more long-term care options and serving our medically complex patient populations.
- The leading causes of death for both men and women in San Francisco are ischemic heart disease, lung cancer and stroke.
- Data show that there are many health care resources available to San Franciscans; however, certain neighborhoods and sub-populations experience significant health disparities and inequities.
    - Black/African American men and women in San Francisco experience disproportionately higher mortality and premature mortality rates compared to other racial/ethnic groups.
    - Black/African American babies in San Francisco have notably higher perinatal and infant mortality rates compared to other racial/ethnic groups.
    - Among San Franciscans, Latinos are at greatest risk for obesity.
    - San Francisco has experienced an increase in active tuberculosis (TB) cases and ranks third statewide. Foreign-born Asians bear the largest TB burden; TB rates among Hispanics have increased significantly.

- The obesity rate is 17.2%, which is lower than the state rate of 22.7%, while the national benchmark for adult obesity is 25%.
- In San Francisco, 8.4% of adults reported having smoked at least 100 cigarettes in their lifetime and currently smoke. This is lower than California (12.1 %) and the nation (17.3 %).
- For San Franciscans ages 15-34, homicide and suicide are the top 2 leading causes of death; drug and alcohol related mortality are among the top 10 leading causes of death.
- Income inequality is growing. San Francisco has the highest degree of income inequality among Bay Area counties, and certain sub-populations are more likely than others to experience poverty.

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.

San Francisco is a densely populated city, with approximately 852,469 residents in a 47 square mile area, according to the United States Census Bureau (as of July 1, 2015). Over the past 5 years, the population grew by 5.9% compared to national population growth of 3.3%. The population characteristics are:

- A decrease in the number of children and families with young children: only 14% of residents are under the age of 18, compared to 24% of Californians.
- More than 40% of residents speak a language other than English at home; 163 different languages are spoken across the City.
- While San Francisco has a lower rate of poverty (13.3%) compared to the national rate (14.8%), San Francisco has the highest degree of income inequality among Bay Area counties, and certain sub-populations are more likely than others to experience poverty.
    - San Francisco's median household income is approximately $73,000; White household median income is $100,000 while Black household median income is $30,000.
    - In 2010, the average home value was $765,000 and rent was $1,500
- Over 1/3 of the population is foreign born; the current racial/ethnic composition includes:
    - 49 % Whites
    - 33 % Asians
    - 15 % Latinos
    - 6 % Blacks
- Over the past few decades, the African American population in SF has dropped by more than half, from a high of 13% in 1970. In absolute terms, the number of

African Americans living in San Francisco dropped from 88,000 in 1970 to fewer than 50,000 in 2014.

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.

UCSF Medical Center and UCSF Benioff Children's Hospital San Francisco are recognized throughout the world for innovative patient care, advanced technology and pioneering research. Together, these hospitals serve as a tertiary and quaternary referral center for Northern California and the Western United States. In addition, we provide primary and secondary care to San Francisco Bay Area (SFBA) residents and serve as a major provider of care to underserved communities in San Francisco County.

On February 1, 2015, UCSF Medical Center at Mission Bay opened its doors to serve women, children and cancer patients. UCSF health care providers are leaders in virtually all specialties, including cancer, heart disease, neurological disorders, immunological disorders, HIV/AIDS and organ transplantation, as well as specialty services for women and children.

- UCSF has 1,019 licensed across its Parnassus, Mount Zion, and Mission Bay locations.
- UCSF's Ambulatory Services include more than 100 clinics in San Francisco and more than 75 outreach clinics, stretching from San Luis Obispo to the Oregon border.
- In 2015, UCSF's hospitals and clinics generated:
  - 1.1 million outpatient visits
  - 43,127 hospital admissions
  - 2,405 baby deliveries
- The annual revenue in FY2015 was $2.2 billion
- In Fiscal Year 2016, UCSF's adult inpatient payer mix was:
  - 43.5% MediCare
  - 26.0% Medi-Cal
  - 29.5% Commercial
  - 1.0% Self Pay / Other
- In Fiscal Year 2016, UCSF's children and OB services payer mix was:
  - 2.0% MediCare
  - 47.1% Medi-Cal
  - 48.6% Commercial
  - 2.2% Self Pay / Other

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.

UCSF implemented Epic's EMR system in April 2011 and has since expanded its use across inpatient, ambulatory, home health, and psychiatry services. Our fully integrated EMR positions UCSF for success in collecting, monitoring and improving upon clinical quality and operational performance metrics.

Data Collection: UCSF's Office of Population Health and Accountable Care oversees the collection of metrics ranging from utilization management to preventive screening and chronic disease management across primary care patients. In addition, UCSF's Department of Patient Safety and Quality collects data pertaining to adults and children seen in inpatient and surgical settings at UCSF. As an academic medical center and research institution, UCSF's faculty practices have a robust infrastructure for collecting patient outcomes, is building capacity to measure patient reported outcomes, and other data relevant to clinical studies across a variety of other specialties.

Reporting: UCSF uses a business intelligence platform to display key performance metrics pertaining to patient experience, inpatient and outpatient operational efficiency, clinical quality and utilization (e.g., FlashDash, Redash, QualDash, PopDash, ExperienceDash). These dashboards allow stakeholders across the institution to identify performance trends by a wide variety of variables

Monitoring: UCSF's Quality Improvement Executive Committee serves as the primary governance body for monitoring performance across all inpatient departments and ambulatory practices. Metrics are reviewed monthly by department analysts, medical directors, practice leaders and frontline staff.

Barriers and Solutions: Some Selected PRIME metrics require the inclusion of external payer membership and claims data. UCSF is quickly developing expertise in this area, with the launch of our Enterprise Data Warehouse in 2014. The innovative metrics pose a reporting challenge, as there is no existing data collection processes. In order to ensure successful PRIME implementation and reporting, UCSF plans to hire Epic Programmers to build EMR documentation workflows to allow for data collection across all required PRIME metrics.

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;*

Care delivery systems and providers must deliver care that is more patient-centered, effective, and affordable. We believe that when the best research, the best education and the best patient care converge, transformational breakthroughs can be achieved. UCSF will continue to capitalize on its traditional strengths while simultaneously embracing new ways of organizing and delivering care, therefore, the UCSF strategic plan 2020 has identified three broad goals:

Goal 1: Lead in Destination Programs: The UCSF Health System will continue to deliver world-class, tertiary and quaternary care, offering patients access to the latest technology, rapid translation of research results into groundbreaking treatments, and the latest clinical trials.

Goal 2: Promote a High Value System of Care: The UCSF Health System will promote a high value system of care by engaging with health care partners in the emerging accountable care organization (ACO) model and alternative payment methodologies. These models call for improving the coordination of services across the care continuum, lowering costs and raising the quality of care for our patients who seek our comprehensive services.

Goal 3: Achieve a Culture of Continuous Process Improvement (CPI): UCSF Health System will examine all aspects of its operations to reduce duplication, integrate and expand existing resources and streamline operations with the objective of improving the value of care we provide. We will empower individuals and teams to develop and adopt practices that enable the delivery of the highest quality services to patients.

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

We have three specific aims for UCSF's PRIME participation:
- To achieve excellent population and clinical health outcomes for our primary care patients
- To implement the highest quality and most cost effective care management and transitional care programs in order to provide seamless patient centered care across the care continuum
- To thoughtfully and carefully address healthcare costs through innovation, Lean process improvement and appropriate stewardship of health care resources, including high cost pharmaceuticals

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;*

UCSF selected cancer screening, palliative care, and high cost pharmaceuticals as optional projects. These projects support our goals in the following ways:

- Cancer screening: UCSF is a world class treatment center. By ensuring that our primary care population is screened for these cancers, we will offer our patients the best opportunity to remain healthy or receive life-saving treatments at the earliest stage of cancer possible.

- Palliative Care: Palliative care gives our elderly, cancer and most complex patients' access to symptom relief, counseling and long term planning resources.

- High Cost Pharmaceuticals: This project aligns with our commitment to ensure our patients are being offered the most effective and affordable drug treatment options; we will also ensure patients have access to adherence management strategies to promote optimal clinical outcomes.

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*

Our approach will be to create a coordinated and connected system of care that spans primary care, specialty care, hospital care, community care, and home care with integration of quality and safety improvement culture at every stage.

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.

The first DSRIP program "jump started" the transformation at UCSF to focus on populations, transitions of care, and long term patient outcomes.   In fact, the DSRIP work contributed to a key element of our current strategic plan (a high value system of care).   Now, under the auspices of the PRIME program, we will both expand and optimize our population health measurement and improvement efforts, focusing specifically on reducing the total cost of care and the integration and expansion of care beyond the boundaries of UCSF Health. By 2020, we will be transformed into a more proactive, patient-centered and efficient care delivery system, while continuing to create the innovative treatments which can improve the health and well-being for all who come to UCSF for care.

3.2 Meeting Community Needs. [No more than 250 words]
Describe how your organization will address health needs at a local level as described in Section 2 of the Plan. The narrative should clearly link the projects you select in Section 4 with the community needs identified in your response to Section 2.1.

As described in our response to Section 2.1, addressing the needs of our growing elderly population is very important. At UCSF, we care for a large group of medically complex elderly patients, who often have advanced chronic diseases. Progression of these disease processes often results in repeated hospital and emergency room admissions. We have recognized the need to create a more patient centered approach by enhancing our home based and ambulatory palliative care infrastructure. Enhancing our ability to coordinate care and manage symptoms for patients who are near the end of life is an ethical imperative at UCSF.

Cancer continues to be a leading cause of death in San Francisco. As a world class cancer treatment center, we believe that by improving our cancer screening rates across our primary care populations, we will make an impact on the health outcomes of our patients by diagnosing cancer in its earliest stages and referring patients for our most advanced treatment options.

Health care costs affect everyone in our community. Because we offer the most advanced cutting edge treatments at UCSF, we have seen dramatic increases in overall pharmaceutical costs. We believe that by instituting high cost pharmaceutical ordering and management protocols, we will be able to ensure that patients are receiving the best and most cost effective treatment options. We plan to work with our managed MediCal health plan partners to help monitor adherence to high cost

medications for our most vulnerable primary care patients.

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).

PRIME aligns very closely with the UCSF strategic goals. As mentioned in section 3.1, UCSF's 5-Year Strategic Plan through 2020 identified three strategic priorities centered around improving access to excellent primary care and specialty medicine, promoting a high value system of care, and establishing a culture of continuous process improvement. In conjunction with this plan, UCSF formed the Office of Population Health and Accountable Care (OPHAC) to serve as a centralized infrastructure for designing, implementing and evaluating interventions focused on value-based care. In addition, UCSF transformed its executive organizational structure to expand physician leadership roles in the areas of Innovation, Quality Improvement, and Faculty Practice accountability. Across all of these areas, UCSF teams participate in data-driven decision making, leveraging business intelligence and analytic tools that span financial, operational, patient safety and quality, and patient/provider experience domains.

UCSF has chosen to centralize the administrative leadership structure for PRIME within OPHAC and has hired a PRIME Program Director, who together with the OPHAC Executive Director and Executive Medical Director, will serve as the lead PRIME implementation team.The PRIME Director will leverage existing forums and committee structures within UCSF to communicate and execute project milestones. These committees are listed in the following section below and include the Excellence in Transitions of Care Committee, the Primary Care Strategies and Operations committees, and the Behavioral Health Integration committee. In addition, OPHAC will engage UCSF's Enterprise Information and Analytics team in the integration of external membership and claims data required for selected PRIME project metrics.

The OPHAC executive team reports up to the Vice President of Population Health and the Executive Vice President of Physician Services at UCSF Health. These leaders also participate in a weekly Senior Leadership Council attended by executives across UCSF Health to ensure alignment with other strategic initiatives.

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.

The PRIME Director within UCSF's Office of Population Health and Accountable Care is responsible for the execution of the PRIME program in conjunction with the office's Executive Director and Executive Medical Director. This leadership team has engaged the following UCSF stakeholder groups:
- Primary Care and Faculty Practice physician and administrative leadership
- Primary Care Behavioral Health Integration Committee
- OB Interdisciplinary Quality Improvement Committee
- Outpatient and inpatient palliative care and symptom management leadership
- Executive leadership across all Physician Services
- Excellence in Transitions of Care Committee
- Leaders from EMR / Clinical Systems Implementation departments
- Patient Experience Department
- Managed MediCal partners at San Francisco Health Plan
- Department of Pharmacy leadership

PRIME leaders will continue to engage in meaningful discussions with each stakeholder group to identify strengths, weaknesses, opportunities and threats for each project and to develop comprehensive project implementation plans.

UCSF will continue to leverage the Patient Advisory Councils (PAC) developed as part of the DSRIP Primary Care Medical Homes initiative. These PACs include a diverse group of primary care patients who meet monthly to discuss and provide feedback on new or existing initiatives. Feedback from these PACs helped inform UCSF's approach for previous DSRIP projects, including patient outreach campaigns used to improve selected immunization and cancer screening rates.

3.5 Cultural Competence and Addressing Health Disparities. [No more than 200 words]

UCSF has a long history of disparities research and strives to address health care disparities in our clinical care delivery. UCSF faculty and physician experts are working on multiple fronts to better understand the causes of health care inequities and to implement promising strategies to eliminate disparities. Our new Chief Quality Officer has mandated that all quality data be stratified and analyzed by REAL data categories to understand where disparities may exist and to plan for how they may be addressed. Currently, every new employee is oriented to the importance of culturally sensitive care and ongoing learning opportunities are available for addressing this care through our learning center. At UCSF all nurses are required to complete an annual cultural

competency assessment to demonstrate understanding of cultural and developmentally appropriate care.   In addition, the UCSF Chancellor has identified improving diversity, inclusion, and elimination of disparities, across all aspects of the campus as one of his highest priorities. However, there is always room to improve. The PRIME project teams will be asked to identify any disparities or cultural issues requiring further analysis and improvement.

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.

UCSF's strategic plan through 2020 places a large focus on value-based care, improved access, and continuous process improvement using Lean methodologies. To this end, UCSF now has an Office of Population Health and Accountable Care that includes a department of Clinical Programs focused on chronic disease management, home-based palliative care and transitional care, as well analytic and project management teams. These teams collaborate with internal and external partners to design, implement and evaluate value-based care interventions that are built with long-term scalability in mind.

Furthermore, UCSF has developed Continuous Process Improvement hub whereby unit-based leadership teams (UBLTs) across the health system are trained on Lean tools and tactics and then empowered to engage their frontline staff on targeted improvement efforts. These UBLTs represent an existing improvement infrastructure spanning all levels of the organization, which will help propel the PRIME projects to success and ensure systematic, long-term sustainability of the program.

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)

Planned implementation approach: At UCSF we have a multidisciplinary primary care behavioral health integration [BHI] committee. In collaboration with the PRIME leadership team, the BHI committee will be charged with the oversight and implementation of the BHI PRIME project.

Adoption of Team Care Model and Training: UCSF will adopt the University of Washington team care model for managing depression and chronic disease across our primary care clinics. Staff and provider learning needs will be assessed and identified. Providers and staff will be trained in motivational interviewing techniques, chronic care management coaching, depression and substance abuse screening and treatment modalities. Patients with significant depression and chronic diseases will be assigned to care management teams as indicated.

Referral Coordination and Care Teams: Clinical pathways and escalation protocols will be developed to help triage patients who screen positive for depression or substance abuse. Specified referral coordinators will be trained for this work and will have access to a continuously updated community referral network, our care management team, our PC embedded psychiatrists and if needed, to Langley Porter, our psychiatric facility.

EMR Workflow Optimization and Enhanced Analytics: Our EMR will be enhanced to include a PHQ2, PHQ9 and SBIRT screening modules. Primary care staff and providers will be trained on the use of the modules. Data and screening scores will be collected and used to monitor and drive performance. A depression registry will be created to monitor high risk patient outcomes and create patient panels for the behavioral health navigators. Providers will have access to psychiatry e-consults.

Target Population: Our target population will be all adults and adolescents (>12) in our primary care clinics, as determined by the screening recommendations and the literature. Implementation of these processes will be staged across our primary care clinics using findings from a readiness assessment and gap analysis.

Vision for Care Delivery: By 2020, UCSF expects to have fully operationalized screening and referral processes for depression and substance abuse. Patients will have access to a wide range of treatment options including 'embedded' PC based

psychiatrists, community resources, dedicated care management teams and specialized high risk psychiatric services at Langley Porter. Long term patient outcomes will be monitored.

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

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

Check, if applicable	Description of Core Components
Applicable	**1.1.7** Ensure systems are in place to support patient linkages to appropriate specialty physical, mental and SUD services. Preventive care screenings, including behavioral health screenings (e.g., PHQ-2, PHQ-9, SBIRT), will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including the provision of brief interventions (e.g., motivational interviewing techniques) to ensure access for further evaluation and treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.
Applicable	**1.1.8** Provide cross-systems training to ensure effective engagement with patients with MH/SUD conditions. Ensure that a sufficient number of providers are trained in SBIRT and/or in other new tools used by providers to ensure effectiveness of treatment.
Not Applicable	**1.1.9** Increase access to Medication Assisted Treatment (MAT) for patients with alcohol and opioid addiction to assist in stabilizing their lives, reducing urges or cravings to use, and encourage greater adherence to treatment for co-morbid medical and behavioral health conditions. For alcohol use disorders these medications include naltrexone, acamprosate, and disulfiram. For opioid addiction, medication assisted treatment (MAT) includes maintenance treatment with methadone and buprenorphine.
Not Applicable	**1.1.10** Ensure the development of a single treatment plan that includes the patient's behavioral health issues, medical issues, substance abuse, social and cultural and linguistic needs. This includes incorporating traditional medical interventions, as well as non-traditional interventions such as gym memberships, nutrition monitoring, healthy lifestyle coaching, or access to culturally and linguistically appropriate peer-led wellness and symptom management groups.
Applicable	**1.1.11** Ensure a culturally and linguistically appropriate treatment plan by assigning peer providers or other frontline worker to the care team to assist with care navigation, treatment plan development and adherence.
Not Applicable	**1.1.12** Ensure that the treatment plan: • Is maintained in a single shared Electronic Health Record (EHR)/ clinical record that is accessible across the treatment team to ensure coordination of care planning. • Outcomes are evaluated and monitored for quality and safety for each patient.

Check, if applicable	Description of Core Components
Applicable	**1.1.13** Implement technology enabled data systems to support pre-visit planning, point of care delivery, care plan development, population/panel management activities, coordination and patient engagement. Develop programs to implement telehealth, eReferral/eConsult to enhance access to behavioral health services.
Applicable	**1.1.14** Demonstrate patient engagement in the design and implementation of the project.
Applicable	**1.1.15** Increase team engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on care model.
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)

Planned implementation approach: Through the DSRIP program, seven of UCSF's eleven primary care sites achieved Patient-Centered Medical Home (PCMH) recognition from NQCA and the remaining four locations will be submitting applications for recognition by the end of 2016. Using the PCMH model as the foundational approach, all of UCSF's primary care sites are going through significant redesign and transformation to improve new patient and same-day access and to deliver proactive and well-coordinated whole-person care. Our patients benefit from an interdisciplinary primary care team with access to pharmacists, licensed clinical social workers and behavioral health navigators. Together, these primary care team members actively engage their empaneled patients using multiple communication tools, ensuring that patients are up-to-date on their chronic disease management and preventive screenings.

In order to achieve success on the PRIME primary care milestones, further standardization is needed across clinic sites to ensure consistent improvement in the areas of preventive and behavioral health screening, chronic disease outcomes and post-discharge care coordination. UCSF will apply Lean process improvement methodology in primary care as a way to better understand and address current bottlenecks to improvement. As part of the Lean process,

primary care teams will be aligning their strategic priorities with PRIME under a "True North" framework, and they will participate in kaizen value stream mapping to establish streamlined, standard work processes that can be scaled across all levels of staff at all primary care clinic sites. Primary Care and OPHAC will work together with the EMR and technical teams to develop the relevant EMR trainings and documentation workflows needed to drive improvement.

Training for Health Coaching: To achieve the PRIME metrics for primary care redesign, UCSF plans to invest in booster trainings for all frontline staff in the areas of panel management, team based care and health coaching using UCSF's Center for Excellence in Primary Care (CEPC). Learning needs will be assessed across all practices and trainings will be offered to build capacity for providers and staff to perform screening and follow-up for depression, tobacco and substance abuse and management of co-morbidities.

Workflow Optimization: In addition, UCSF will continue to pursue protocolized workflows that allow staff to work at the tops of their licenses to deliver the necessary care at the point-of-service. For example, UCSF is currently working to expand the scope of its Medical Assistants so that they may administer selected immunizations and perform point-of-care diabetes HbA1c testing and foot exams for diabetic patients. Furthermore, primary care practices are participating in Lean process improvement methodologies to establish streamlined, standard work processes that can be scaled across primary care sites.

EMR Optimization: To drive performance improvement across front line staff and clinicians, UCSF will continue to enhance its analytics dashboards and explore the use of Epic's Healthy Planet tool for streamlining data and related workflows for population health management. In particular, UCSF will explore available tools to deliver real-time, provider- and practice-level performance reports that are embedded within the EMR and allow for prompt action on potential care delivery gaps. UCSF will also continue to explore other apps and interactive voice technologies available to effectively engage patients in managing their health.

Target Population: Although UCSF will apply the relevant PRIME denominator population when reporting metrics, our primary care interventions will target all patients empaneled to primary care providers. As of March 2016, our primary care population includes over 76,000 patients across eleven pediatric, family medicine, and internal medicine practices. This population is roughly 25% children, 78% adult, and 7% geriatric patients age 75 and over.

Vision for Care Delivery: By the conclusion of PRIME, UCSF will have fully implemented the PCMH model across all of its sites, where patients will receive highly coordinated care that effectively addresses chronic condition management and health promotion as a means to accomplish the triple aim of better outcomes, better patient

experiences, and lower costs of care. Recognizing that the evolving health care market is placing additional responsibility on the primary care physician, UCSF will also have improved provider satisfaction and reduced burnout through a combination of approaches (e.g.: EMR provider workflow optimization, advances in scopes of practice for support staff, and competitive compensation packages for physicians).

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

Check, if applicable	Description of Core Components
Applicable	**1.2.1** Conduct a gap analysis of practice sites within the DPH/DMPH system.
Applicable	**1.2.2** Primary care practices will demonstrate advancement of their PCMH transformation through the use of a nationally-recognized PCMH methodology.
Applicable	**1.2.3** Hiring and training of frontline workforce (e.g., medical assistants, community health workers, promotoras, health navigators or other non-licensed members of the care team) to be responsible for coordination of non-clinical services and elements of the care plan.
Applicable	**1.2.4** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population/panel management activities, care coordination, patient engagement, and operational and strategic decisions including a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. • Implementation of EHR technology that meets meaningful use (MU) standards.
Applicable	**1.2.5** Ongoing identification of all patients for population management (including assigned managed care lives): • Manage panel size, assignments, and continuity to internal targets. • Develop interventions for targeted patients by condition, risk, and self-management status. • Perform preventive care services including mental health and substance misuse screenings and brief interventions (e.g., PHQ-9, SBIRT).
Applicable	**1.2.6** Enable prompt access to care by: • Implementing open or advanced access scheduling. • Creating alternatives to face-to-face provider/patient visits. Assigning frontline workers to assist with care navigation and non-clinical elements of the care plan.

Check, if applicable	Description of Core Components
Applicable	**1.2.7** Coordinate care across settings: • Identification of care coordinators at each primary care site who are responsible for coordinating care within the PCMH as well as with other facilities (e.g., other care coordinators or PCMH/DPH/DMPH high risk care managers): o Establish onsite care/case managers to work with high risk patients and their care teams, or develop processes for local care coordinators to work with a central complex care management program for these patients Implement processes for timely bi-directional communication and referral to specialty care (including mental health and substance use disorder services), acute care, social services and community-based services.
Applicable	**1.2.8** Demonstrate evidence-based preventive and chronic disease management.
Applicable	**1.2.9** Improve staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the team-based care model to ensure effective and efficient provision of services (e.g., group visits, medication reconciliation, motivational interviewing, cognitive behavioral therapy and Medication-Assistance Treatment (MAT)).
Applicable	**1.2.10** Engage patients using care plans, and self-management education, and through involvement in the design and implementation of this project.
Applicable	**1.2.11** Improve the accuracy and completeness of race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI) data, and use that data to identify and reduce disparities in one or more Primary Care Redesign project metrics by: • Adding granular REAL and SO/GI data to demographic data collection processes and training front-line/registration staff to gather complete and accurate REAL/SO/GI data. • Developing capacity to track and report REAL/SO/GI data, and data field completeness. • Implementing and/or refining processes for ongoing validation of REAL/SO/GI data. • Developing capacity to stratify performance metrics by REAL/SO/GI data and use stratified performance data to identify disparities for targeted interventions. • Developing capacity to plan and implement disparity reduction interventions with input from patients and community stakeholders.

Check, if applicable	Description of Core Components
	• Developing dashboards to share stratified performance measures with front-line staff, providers, and senior leadership.
Applicable	**1.2.12** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

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

Planned implementation approach: UCSF's PRIME leadership team will collaborate closely with the UCSF Faculty Practice Office and its Access Improvement team to execute the specialty redesign project. UCSF's specialty initiatives are focused on improving access and coordination with referring physicians. The PRIME leadership team will coordinate with UCSF's Lean improvement team to lead targeted discovery sessions and identify interventions that will improve specialty access and referral turnaround time. Interventions will then be tested as proofs-of-concept, with close monitoring of outcome and process metrics to determine impact of any new workflows or technologies.

EMR Optimization and Analytics: UCSF's EMR is fully integrated across inpatient and outpatient settings, which allows providers easily view the care being provided to their patients across the institution. UCSF can further improve upon provider-to-provider communication by building automated referral tools to ensure consistency in closing the referral loop. An analysis will be conducted to identify which specialties generate a high volume of referrals without timely closure, so that EMR optimization can be phased and targeted to areas with most opportunity for improvement.

Expansion of Alternative Visit Types: As part of the DSRIP program, UCSF launched a comprehensive e-consult program that allows primary care providers to seek specialty input when managing their patients' conditions. This helped to free up access in Specialty Care and improve patient and provider satisfaction. UCSF will continue to leverage its e-consult infrastructure, and will also pursue expansion of telehealth services and other alternative visit types as appropriate.

Workflow Enhancements and Training: Support staff at selected clinics will be trained on referral triage processes and timely communication with the referring provider and patient. In addition, existing care coordination staff will be trained to deliver evidence-based transitional care shown to reduce post-procedure complications and ED utilization.

Target Population: Our target population will be all primary care adults and children who are referred to UCSF specialty care. Implementation of these specialty care interventions will be staged across our clinics using findings from a readiness assessment and gap analysis.

Vision for Care Delivery: By 2020, UCSF will position its specialty programs for success in value based care models by implementing a standardized approach to significantly improve patient access and coordination of care transitions, and by monitoring patient outcomes and achieving efficiencies to deliver higher quality at lower cost.

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

Check, if applicable	Description of Core Components
Applicable	**1.3.1** Develop a specialty care program that is broadly applied to the entire target population.
Not Applicable	**1.3.2** Conduct a gap analysis to assess need for specialty care including mental health and SUD services (analysis to include factors impacting ability to access specialty care), and the current and ideal state capacity to meet that need. Benchmark to other CA Public Health Care systems.
Applicable	**1.3.3** For ideal state analysis, include potential impact of increased primary care capacity to manage higher acuity conditions either independently, or in collaboration with, specialty care, so as to reduce the need for in-person specialty care encounters (e.g., insulin titration, IBS management, joint injections, cognitive behavioral therapy (CBT) or MAT).
Not Applicable	**1.3.4** Engage primary care providers and local public health departments in development and implementation of specialty care model.
Not Applicable	**1.3.5** Implement processes for primary care/specialty care co-management of patient care.
Applicable	**1.3.6** Establish processes to enable timely follow up for specialty expertise requests.
Applicable	**1.3.7** Develop closed loop processes to ensure all requests are addressed and if in person visits are performed, that the outcome is communicated back to the PCP.

Check, if applicable	Description of Core Components
Applicable	**1.3.8** Ensure that clinical teams engage in team- and evidence-based care.
Applicable	**1.3.9** Increase staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the care model.
Applicable	**1.3.10** Develop and implement standardized workflows for diversified care delivery strategies (e.g., shared medical visits, ancillary led services, population management, telemedicine services) to expand access and improve cost efficiency.
Not Applicable	**1.3.11** Adopt and follow treatment protocols mutually agreed upon across the delivery system.
Not Applicable	**1.3.12** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population management activities and care coordination/transitions of care. Ensure that timely, relevant, and actionable data are used to support patient engagement, PCP collaboration, and drive clinical, operational and strategic decisions including continuous quality improvement (QI) activities.
Applicable	**1.3.13** Implement EHR technology that meets MU standards.
Not Applicable	**1.3.14** Patients have care plans and are engaged in their care. Patients with chronic disease (including MH/SUD conditions) managed by specialty care have documented patient-driven, self-management goals reviewed at each visit.
Not Applicable	**1.3.15** Improve medication adherence.
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	**1.3.18** Demonstrate engagement of patients in the design and

Check, if applicable	Description of Core Components
Applicable	implementation of the project.
Applicable	**1.3.19** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.
Not Applicable	**1.3.20** Test use of novel performance metrics for redesigned specialty care models.

⊠ 1.6 – Cancer Screening and Follow-up

Rationale: UCSF selected the Cancer Screening and Follow-up optional project to further build upon the primary care infrastructure put in place during the prior DSRIP program. UCSF has already made significant progress through development of several cancer registries, implementation of panel management in-reach and outreach workflows in primary care. However, with the growth of primary care from five to eleven locations in the past several years, UCSF needs to continue to improve upon these screening domains. In addition, UCSF's selection of the cancer screening project ties in seamlessly with other strategic initiatives within the organization, including the expansion of UCSF's Cancer Center and inpatient and outpatient Palliative Care Services.

Planned implementation approach: The PRIME leadership team will collaborate with the Primary Care Strategies and Operations committees to execute the Cancer Screening project. Specifically, UCSF will identify learning needs of provider and staff and will optimize workflows for engaging patients in screening and follow-up for cervical cancer, breast cancer, and colorectal cancer. As mentioned previously as part of the Primary Care Redesign section, UCSF plans to apply Lean process improvement methodologies to identify existing bottlenecks and establish standard workflows that can be scaled across primary care sites. In addition, analytic dashbords will be used to deliver real-time provider- and practice-level performance reports to drive improvement and allow for timely action on cancer screening gaps.

Training for Health Coaching: To improve cancer screening rates, UCSF will invest in booster trainings for all frontline staff in the areas of outreach panel management and health coaching using UCSF's Center for Excellence in Primary Care (CEPC) with a focus on cancer care, outcomes and the importance of high quality cancer screening.

Workflow Optimization: UCSF will continue to pursue protocolized workflows that allow staff to work at the top of their licenses to deliver the necessary care at the point-of-service. Staff will be allowed to pend orders and direct schedule for mammograms and other diagnostic tests.

EMR Optimization and patient engagement technologies: To drive performance improvement across front line staff and clinicians, UCSF will continue to enhance its analytics dashboards and explore the use of Epic's Healthy Planet tool for streamlining data and related workflows for population health management. UCSF will also continue to explore other apps and interactive voice technologies available to effectively engage patients in managing their health and collecting patient-reported data.

Target Population: UCSF cancer screening interventions will target all patients (regardless of payer) seen by our primary care providers. The target population age range is tailored for each selected cancer screening area as follows:

- Breast Cancer Screening: Women between 50 and 75 years of age who are empaneled to any of UCSF's 11 primary care clinic sites
- Cervical Cancer Screening: Women between 24 and 65 years of age who are empaneled to any of UCSF's 11 primary care clinic sites
- Colorectal Cancer Screening: All patients (males and females) between 51 and 76 years of age who are empaneled to any of UCSF's 11 primary care clinic sites

UCSF will continue to use evidence-based guidelines for screening frequency such as those endorsed by the US Preventive Services Taskforce, the American Cancer Society, and other nationally recognized clinical committees.

Vision for Care Delivery: UCSF's vision for 2020 is to achieve top performance in cancer screening rates among primary care patients, and to be a world class cancer treatment center with seamless referral and follow-up processes between primary and specialty care oncology teams.

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

Check, if applicable	Description of Core Components

Applicable	**1.6.1** Develop a multi-disciplinary cross-participating PRIME entity task force to identify principle-based expected practices for screening and follow-up for the targeted services including, but not limited to:
	• Standard approach to screening and follow-up within each DPH/DMPH.
	• Screening:
	  o Enterprise-wide standard approach to screening (e.g., ages, frequency, diagnostic tool).
	• Follow-up for abnormal screening exams:
	  o Clinical risk-stratified screening process (e.g., family history, red flags).
	Timeliness (specific time benchmark for time from abnormal screening exam to diagnostic exam).

Applicable	**1.6.2** Demonstrate patient engagement in the design and implementation of programs.
Applicable	**1.6.3** 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.

Check, if applicable	Description of Core Components
Applicable	**1.6.4** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to USPSTF A and B Recommendations.
Applicable	**1.6.5** Improve access to quality care and decrease disparities in the delivery of preventive services.
Applicable	**1.6.6** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
Applicable	**1.6.7** 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	**1.6.8** Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.
Applicable	**1.6.9** Implement a system for continual performance management and rapid cycle improvement that includes feedback from patients, community partners, front line staff, and senior leadership.

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)

Planned implementation approach: At UCSF, we have a robust, multidisciplinary Obstetrics Quality Improvement [OBQI] committee. In collaboration with the PRIME leadership team, the OBQI committee will be charged with the oversight and implementation of the Perinatal PRIME project.

Adoption of Baby Friendly Hospital Model and Training: UCSF will adopt the baby friendly training model. This will require significant training resources and a robust implementation plan. Relevant staff and provider learning needs will be assessed and identified. Providers and staff will be trained in baby friendly principles. UCSF will seek baby friendly designation as indicated in the metric specifications. We will engage in the CMQCC learning collaborative and share best practices with other organizations.

Enhancement of Patient Engagement Technologies: We plan to leverage our transitional care outreach program to ensure new moms and their babies have a safe and pleasant transition to home. Our outreach phone call and texting platform will be leveraged to engage high risk patients in their post-partum care. We will collect patient reported response data to further refine our discharge and transitional care interventions.

Enhanced Analytics and Performance Improvement Methodologies: Our analytic processes will be enhanced to ensure compliance with CMQCC data standards. Analytic staff will be trained to these standards and how to utilize the CMQCC database and reporting platform to monitor and drive performance. If indicated, a registry will be built to monitor prenatal and post natal care performance and outcomes.

Target Population: While the PRIME target population for this project is the PRIME denominator, the UCSF target population will be for all mothers and babies that give birth at UCSF; projected to be about 2,800 live births in FY17.

Vision for Care Delivery: By 2020, UCSF expects to continue to be a premium destination for childbirth and care for all mothers and to ensure the best possible outcomes for high risk pregnancies. We expect to reduce newborn readmissions related to breast feeding issues and dehydration, and will maintain excellent outcomes in the delivery of perinatal care.

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

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

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

Planned implementation approach: At UCSF, we have a robust, multidisciplinary Excellence in Transitions of Care [ETOC] committee. In collaboration with the PRIME leadership team, the ETOC committee will be charged with the oversight and implementation of the PRIME Care Transitions project. UCSF's current care transitions program includes a post-discharge outreach team that addresses patient needs at 48 hours post-discharge. This team will be trained to address the PRIME activities focused on post-discharge follow up visits and medication reconciliation. Within the inpatient setting, UCSF's designated members of ETOC will reassess current discharge planning processes and identify discharge workflow enhancements needed to ensure consistent medication reconciliation at discharge and timely transmission of the transition record. Lastly, UCSF's ETOC committee will oversee an analysis to identify variability in discharge trends across departments and conduct targeted audits and trainings to sustain long-term improvement.

In order to reduce readmissions and admissions for ambulatory sensitive conditions, UCSF will develop enhanced algorithms for identifying patients who are at high risk of readmission or high utilization and engage these patients in health coaching, chronic condition management plans, and assigned a care coordinator as indicated.

Enhancement of Patient Engagement Technologies and Training: UCSF will pursue teach-back training for nurses in selected inpatient departments to ensure effective communication and coordination as patients transition from the hospital. In

addition, UCSF will continue to leverage its transitions of care program for enhanced high risk patient outreach and 30 day medication reconciliation by pharmacists, if required. Opportunities for the use of telehealth will also be explored to deliver timely health care services to identified high risk patients.

Enhanced Analytics and EMR Workflow Optimization: Our EMR will be optimized to ensure seamless discharge transitions processes, medication reconciliation, and transmission of the after visit summary [AVS] for both the primary care provider and the patient. Electronic decision support will be utilized where it is appropriate and relevant, and providers and staff will be trained on the use of enhanced documentation workflows. Documentation workflow and content completeness compliance data will be collected and used to monitor and drive performance.

Enhancing Post-Acute Partnerships: UCSF leads a post-acute care collaborative with five local SNFs. Members of this collaborative have agreed to share key performance metrics and improve upon discharge processes, provider communication across entities, and to jointly develop care pathways for identified patient populations. UCSF has also entered a formal partnership with Hospice By the Bay to effectively deliver home-based palliative care services to reduce readmissions and better coordinate care for these vulnerable patients.

Target Population: Our target population will be all primary care patients discharged from the hospital. Implementation of these interventions will be staged across relevant departments using findings from a readiness assessment and gap analysis.

Vision for Care Delivery: By 2020 UCSF plans to achieve improved patient experience, reduction in unnecessary readmissions and ED utilization, and improved patient reported outcomes.

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

Check, if applicable	Description of Core Components
Applicable	2.2.1 Develop a care transitions program or expand a care transitions program to additional settings (e.g., emergency department), or to additional populations, using or adapting at least one nationally recognized care transitions program methodology.
Applicable	2.2.2 Establish or expand on a system to track and report readmission rates, timeliness of discharge summaries, and other transition processes, and investigate system-specific root causes/risk factors for readmission, using quantitative and qualitative information to identify the key causes of readmissions, including physical, behavioral and social factors.

Check, if applicable	Description of Core Components
Applicable	**2.2.3** Develop and implement a process, including utilization of data and information technology, to reliably identify hospitalized patients at high-risk for readmission.

Applicable	**2.2.4** Develop standardized workflows for inpatient discharge care:
	• Optimize hospital discharge planning and medication management for all hospitalized patients.
	• Implement structure for obtaining best possible medication history and for assessing medication reconciliation accuracy.
	• Develop and use standardized process for transitioning patients to sub-acute and long term care facilities.
	• Provide tiered, multi-disciplinary interventions according to level of risk:
	  o Involve mental health, substance use, pharmacy and palliative care when possible.
	  o Involve trained, enhanced IHSS workers when possible.
	  o Develop standardized protocols for referral to and coordination with community behavioral health and social services (e.g., visiting nurses, home care services, housing, food, clothing and social support).
	Identify and train personnel to function as care navigators for carrying out these functions.

Applicable	**2.2.5** Inpatient and outpatient teams will collaboratively develop standardized transition workflows: • Develop mechanisms to support patients in establishing primary care for those without prior primary care affiliation. Develop process for warm hand-off from hospital to outpatient provider, including assignment of responsibility for follow-up of labs or studies still pending at the time of discharge.
Applicable	**2.2.6** Develop standardized workflows for post-discharge (outpatient) care: • Deliver timely access to primary and/or specialty care following a hospitalization. • Standardize post-hospital visits and include outpatient medication reconciliation.
Applicable	**2.2.7** Support patients and family caregivers in becoming more comfortable, competent and confident in self-management skills required after an acute hospitalization by providing: • Engagement of patients in the care planning process. • Pre-discharge patient and caregiver education and coaching. • Written transition care plan for patient and caregiver. • Timely communication and coordination with receiving practitioner. Community-based support for the patient and caregiver post

Check, if applicable	Description of Core Components
	hospitalization focusing on self-care requirements and follow-up care with primary and specialty care providers.
Applicable	**2.2.8** Engage with local health plans to develop transition of care protocols that ensure: coordination of care across physical health, substance use disorder and mental health spectrum will be supported; identification of and follow-up engagement with PCP is established; covered services including durable medical equipment (DME) will be readily available; and, a payment strategy for the transition of care services is in place.
Applicable	**2.2.9** Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**2.2.10** Increase multidisciplinary team engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on care model.
Applicable	**2.2.11** Implement a system for continual performance feedback and rapid cycle improvement that uses standard process improvement methodology and that includes patients, front line staff and senior leadership.

⊠ 2.3 – Complex Care Management for High Risk Medical Populations (required for DPHs)

Planned implementation approach: The Office of Population Health has a robust multidisciplinary complex care team that delivers home based and office based complex care co-managed with the patient's Primary Care Physician [PCP]. In collaboration with the PRIME leadership team, the OPH clinical leadership team will be charged with the oversight and implementation of the PRIME Care Transitions project.

Enhanced Analytics and Registry Build: UCSF will use the EMR and our population health analysts for the identification of our medically complex, high risk, high utilizer cohort of patients. We will make this patient cohort designation highly visible and transparent across the care continuum, so all care providers understand this designation. We will build a dynamic registry of this patient cohort to monitor access, utilization, health outcomes and other relevant metrics.

Clinical Pathway Development and Training: Patients identified into our medically complex cohort, will be cared for by our care management team (in conjunction with the PCP). Evidenced based clinical pathways and protocols will be developed and refined

to address the social and behavioral determinants of health and other complex care needs. These pathways will address issues such as caregiver support, cognitive decline, behavioral health and health literacy, among others. Staff will be trained in all aspects of this care and undergo annual competency assessment for skills such as motivational interviewing, advanced care planning, health screening and culturally appropriate care.

Enhancement of Patient Engagement Technologies: UCSF will explore the use of innovative patient engagement technologies to maximize and enhance provider and staff efficiency and reach. Technologies such as tele-health, phone call and texting outreach, and interactive technologies that address social isolation, biometric monitoring and early problem resolution are planned. UCSF also plans to engage chaplains and community organizations for the provision of spiritual and faith based support.

Target Population: The target population will be the medically complex high utilizer patients empaneled to primary care. Criteria for this cohort will be developed through collaboration with primary care leadership, ACO leadership, OPH clinical programs leadership and the acute care case management department. Patients will be selected for our complex care program based on medical complexity, health system utilization, and ability to engage in team based care.

Vision for Care Delivery: By 2020, UCSF expects to decrease ED and inpatient utilization, improved clinical patient outcomes (lowered HgbA1c, improved depression scores, improved BMI, etc.), and improve referral to palliative care services as indicated. UCSF will also develop and test patient reported outcome metrics as a national NCQA pilot site participant in their goal based care initiative.

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

Check, if applicable	Description of Core Components
Applicable	**2.3.1** Develop a complex care management program at one site or with one defined cohort, or expand an existing program from a pilot site to all sites or to additional high-risk groups and demonstrate engagement of patients in the design and implementation of the project.
Applicable	**2.3.2** Utilize at least one nationally recognized complex care management program methodology.
Applicable	**2.3.3** Identify target population(s) and develop program inclusion criteria based on quantitative and qualitative data (e.g., acute care utilization, lack of primary care utilization, number of high-risk medical mental or SUD conditions, polypharmacy, primary care input, functional status, patient activation, social support or other factors). Include patient factors associated with a higher probability of being impacted by complex care management.

Check, if applicable	Description of Core Components
Applicable	**2.3.4** Conduct a qualitative assessment of high-risk, high-utilizing patients.
Applicable	**2.3.5** Establish data analytics systems using clinical data sources (e.g., EHR, registries), utilization and other available data (e.g., financial, health plan, zip codes), to enable identification of high-risk/rising risk patients for targeted complex care management interventions, including ability to stratify impact by race, ethnicity and language.
Applicable	**2.3.6** Develop a multi-disciplinary care team, to which each participant is assigned, that is tailored to the target population and whose interventions are tiered according to patient level of risk.
Applicable	**2.3.7** Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets.
Applicable	**2.3.8** Implement evidence-based practice guidelines to address risk factor reduction (smoking cessation/immunization/substance abuse identification and referral to treatment/depression and other behavioral health screening, etc.) as well as to ensure appropriate management of chronic diseases: • Use standardized patient assessment and evaluation tools (may be developed locally, or adopted/adapted from nationally recognized sources). Use educational materials that are consistent with cultural, linguistic and health literacy needs of the target population.
Applicable	**2.3.9** Ensure systems and culturally appropriate team members (e.g. community health worker, health navigator or promotora) are in place to support system navigation and provide patient linkage to appropriate physical health, mental health, SUD and social services. Ensure follow-up and retention in care to those services, which are under DPH/DMPH authority, and promote adherence to medications.
Applicable	**2.3.10** Implement technology-enabled data systems to support patients and care teams throughout the care management program including patient identification, pre-visit planning, point-of-care delivery, care plan development and population/panel management activities.
Applicable	**2.3.11** Implement a data-driven system for rapid cycle improvement and performance feedback to address quality and safety of patient care, which includes patients, front line staff and senior leadership.

☒ 2.7 – Comprehensive Advanced Illness Planning and Care

Rationale: UCSF has been a national leader and has significant expertise in the delivery of palliative care services. We chose this project because we have local expertise, robust interest from a variety of disciplines, and an organizational need to expand our services in the ambulatory environment.

Planned implementation approach: UCSF has a multidisciplinary continuity of care [COC] steering committee and a well-developed strategic plan for the expansion of palliative care services. In collaboration with the PRIME leadership team, the COC committee will be charged with implementation of this PRIME project.

Primary Palliative Care Training: Palliative care begins with an understanding about the importance of advanced care planning and being comfortable with having these conversations with patients. This requires a concentrated effort around informing and training providers and staff on how to become competent in this care. Staff and provider learning needs will be assessed and identified. Providers and staff will be trained in primary palliative care principles and advanced care planning.

Enhanced Analytics and EMR Workflow Optimization: Our EMR will be enhanced to cohort advanced care plans, treatment preferences, surrogate decision makers and other relevant long term care plans into one designated area of the EMR. All patients in primary care who are greater than 65 will be screened for an advanced care plan or surrogate decision maker. Staff will be trained on the how to screen and coach patients. Screening data will be collected and used to monitor and drive performance.

Ambulatory Palliative Care Infrastructure: A comprehensive ambulatory care needs assessment and a staffing plan will be performed. Technologies, such as telemedicine and e-consult will be implemented. Enhanced partnerships with community organizations such as Hospice by the Bay will be leveraged and expanded**.**

Target Population: Because this project covers a wide range of interventions, the relevant populations will be targeted as appropriate. Our target population in primary care will be all adults >65 and/or those that have relevant diagnoses such as cancer or end stage heart failure, or as determined by the screening recommendations and the literature. Implementation of these processes will be staged across our primary care clinics as appropriate, after the completion of a readiness assessment.

Vision for Care Delivery: By 2020, UCSF expects to have a fully implemented and operational advanced care planning screening process. Patients will have access to a wide range of palliative care and end of life treatment options. Partnerships with community agencies will be strengthened and expanded. We expect to see acute care utilization decreases in patients receiving home based palliative care and symptom management services. We also expect to monitor and report patient reported outcomes and expect to see improved patient experiences and quality of life scores.

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: • Total, active and individualized patient care, including comprehensive assessment, inter-professional care planning and care delivery. • Support for the family. • Interdisciplinary teamwork. • Effective communication (culturally and linguistically appropriate). • Effective coordination. • Attention to quality of life and reduction of symptom burden. • 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: • 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. 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.
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.
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 advanced illness and provide grief counseling and support to the family after death of their loved ones.

Check, if applicable	Description of Core Components
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.
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

☒ 3.3 – Resource Stewardship: Therapies Involving High Cost Pharmaceuticals

Rationale: Given UCSF's focus on value-based care and the application of LEAN methodologies, our organization selected the High Cost Pharmaceuticals project for three primary reasons:

1) The project provides a valuable framework for learning about medication ordering trends and identifying opportunities for cost efficiencies.

2) As a tertiary and quaternary academic medical center, UCSF has had limited experience with standardized physician ordering protocols and recognizes the need to build decision support tools to stay competitive in the evolving health care market.

3) A focus on resource stewardship for high cost pharmaceuticals will positively influence UCSF's performance within existing and upcoming participation in accountable care and alternative payment programs.

Planned implementation approach:

Development of a multi-disciplinary team: A pharmaceutical resource stewardship committee will be developed with representation from our EMR Clinical Systems Implementation team, Department of Pharmacy, and physician leads from selected Faculty Practices and inpatient departments. This committee will have oversight over the medication selection and protocol content development.

Enhanced Analytics and Data: The PRIME leadership team will collaborate closely with the Department of Pharmacy to perform a comprehensive analysis of pharmaceutical ordering trends to identify which medication classes are cost drivers either due to purchase price or the high volume of medication orders. UCSF also plans to partner with San Francisco Health Plan to develop secure data sharing and integration processes that will allow our team to incorporate membership and pharmacy claims into the reported PRIME metrics.

EMR Optimization and Clinical Decision Support: The EMR Clinical Systems Implementation team will assist in the development of decision support tools that are clinically appropriate and evidence-based. Efforts will be made to leverage the EMR's smart form and smart text capabilities to ensure that physician documentation burden is

minimal. Content and workflows will be analyzed to drive performance and improve functionality

Target Population: Because the interventions for this project are wide ranging, several populations have been identified. Internal improvement efforts will be payer and encounter agnostic and will be influenced by which pharmaceuticals are identified as high cost for the institution. Depending on results from the analysis, ordering protocols may target patients being cared for in both ambulatory and inpatient settings, regardless of primary care empanelment. There will be a concerted effort to focus adherence interventions on our managed MediCal population.

Vision for Care Delivery: By 2020, UCSF will have implemented at least 12 evidence-based protocols for selected high cost pharmaceuticals, and will have improved care team workflows for ensuring review and adherence to medications. These efforts will position UCSF for success in future accountable care and alternative payment programs.

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. • Using purchase price data, identify the top 20 medications and medication classes, focusing on the following: Analgesics, Anesthetics, Anticoagulants, Anti-Neoplastics, Diabetes, Hepatitis C, Immunoglobulins, Mental Health (Anti-Depressants/Sedatives/ Anti-Psychotics), Respiratory (COPD/Asthma), Rheumatoid Arthritis. o Exclude Anti-Infectives and Blood Products (addressed in separate PRIME Projects).

Check, if applicable	Description of Core Components
Applicable	**3.3.4** Develop processes for evaluating impact of high-cost, high-efficacy drugs, particularly drugs to treat conditions (e.g., HCV) or to address circumstances (e.g., oral anticoagulants for patients without transportation for blood checks) more prevalent in safety net populations: • Consider criteria that include ability of identified medications to improve patient health, improve patient function and reduce use of health care services.
Applicable	**3.3.5** Develop processes to impact prescribing by providers by establishing standards of care regarding prescribing of high cost pharmaceuticals, including: • Use of decision support/CPOE, evidence-based guidelines and medical criteria to support established standards. • Develop processes to improve the appropriate setting for medication delivery including, transitioning pharmaceutical treatment to the outpatient setting wherever possible. • Promote standards for generic prescribing. • Promote standards for utilizing therapeutic interchange.
Not Applicable	**3.3.6** Improve the process for proper billing of medications, through clinician education and decision support processes.
Not Applicable	**3.3.7** Develop formulary alignment with local health plans.
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.
Not 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.
Applicable	**3.3.10** Develop processes for working with providers with prescribing patterns outside established standards, to identify and reduce barriers to meeting prescribing standards: • Develop guidelines and provide staff training on methods for engaging patients in shared decision making for developing treatment plans within the context of the established standards.

Check, if applicable	Description of Core Components
Applicable	**3.3.11** Maximize access to 340b pricing: • Share templates for contracting with external pharmacies. To improve program integrity, share tools for monitoring of 340b contract compliance.

Please complete the summary chart:

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

Section 5: Project Metrics and Reporting Requirements

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

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

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

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

Section 6: Data Integrity

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

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

Section 7: Learning Collaborative Participation

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

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

Section 8: Program Incentive Payment Amount

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

Total computable 5-year PRIME plan incentive payment amount for:
- DY 11 $ 44,220,400
- DY 12 $ 44,220,400
- DY 13 $ 44,220,400
- DY 14 $ 39,798,360
- DY 15 $ 33,828,606

Total 5-year prime plan incentive amount: $ 206,288,166

Section 9: Health Plan Contract (DPHs Only)

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

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

Section 10: Certification

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

Appendix- Infrastructure Building Process Measures

(N/A FOR UCSF)

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