QUALITY LEADERS AWARDS

For more than 20 years, CAPH/SNI has delivered the Quality Leaders Awards (QLAs) to recognize outstanding initiatives across California's public health care systems. The QLAs honor the good work underway to achieve members' collective 2020 vision:

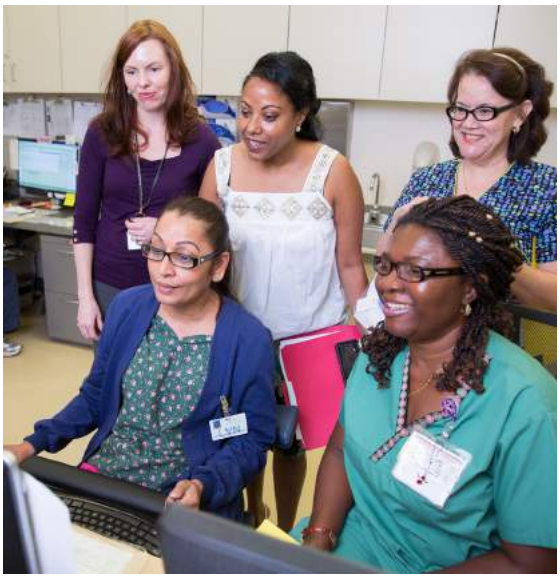
By 2020, public health care systems will become models of integrated care that are high value, high quality, patient-centered, efficient and equitable, with great patient experience and a demonstrated ability to improve health care and the health status of populations.

Top Honor	Recognizes an outstanding effort to improve system integration, expand access, and provide the highest quality of care.
Performance Excellence Award	Recognizes an outstanding effort to improve care processes by removing waste, advancing clinical quality, and/or enhancing patient experience.
Data-Driven Organization Award	Recognizes an outstanding effort to build data infrastructure, develop data analytics capacity, and/or leverage data to improve clinical care.
Advanced Primary Care Award	Recognizes an outstanding effort to deliver "right place, right time care" and, ultimately, to improve population health.

TOP HONOR

KAISER PERMANENTE (KP)
CLINICAL SYSTEMS DEVELOPMENT AWARD

Contra Costa Health Services
Advanced Access Bundle



The continued implementation of the Affordable Care Act has meant an influx of new patients in every one of California's public health care systems. For Contra Costa Health Services (CCHS), this has translated into 35,000 new patients in the previous fifteen months alone.

These new patients were being added to a system where "lack of timely access to clinic appointments" was already the number one complaint voiced by patients. Contra Costa's team knew that a redesign of their decades-old appointment system was needed.

In most offices even today, providers' schedules are booked weeks, if not months, in advance. This was how it worked at CCHS as well, until a newly formed Ambulatory Care Redesign Team (ACRT) determined that the system would need to be streamlined and made more adaptable.

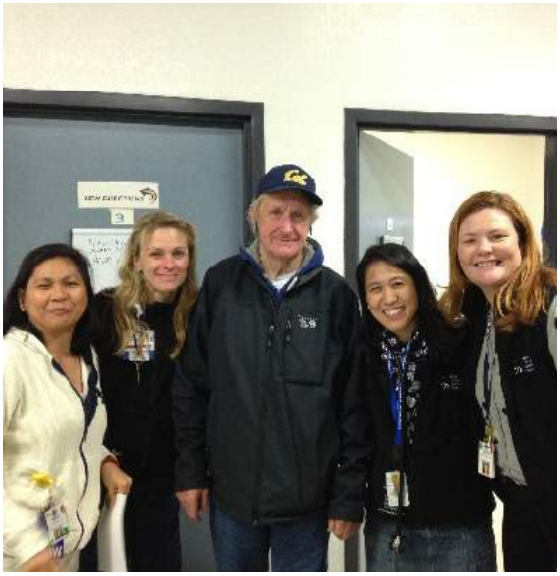
Seeing the need, Contra Costa's team created Advanced Access Scheduling, a model that uses an open template, and continuously balances supply and demand to let patients, both new and old, be seen at a time that works for them. The system has very few slots reserved for special situations or patient types, a departure from how it had worked previously. The Advanced Access Bundle includes this scheduling model as well as other strategic initiatives, including a focus on consistent nurse/provider teams, the establishment of an RN telephone clinic, the extension of visit intervals for patients, and pre-visit phone calls to determine whether an in-person visit is necessary, and ensure that patients are prepared if they are going to come in.

The success of the Advanced Access Scheduling model is dependent on engaged stakeholders, including patient representatives, and teams of nurses and providers engaging in strong communication. Results have been dramatic. New patient no-show rates are down 28%, and clinics have reduced their median third-next-available appointments by as much as 62%.

The Advanced Access initiative was kicked off at CCHS's Martinez Health Center and Miller Wellness Center in January of 2015, spread to both of its Concord Health Centers in April, and then to the West County Health Center and North Richmond Health Center in July – accounting for more than 50% of the system's total patient population. CCHS plans to spread the model across all its primary care clinics by the middle of 2016.

PERFORMANCE EXCELLENCE AWARD

Santa Clara Valley Health & Hospital System
Improving Readmission Rates for Homeless Persons in a Public Hospital System



Santa Clara County has the nation's 4th highest chronically homeless population, with six thousand people on the streets or in insecure housing on any given night. These individuals are some of Santa Clara Valley Health & Hospital System's (SCVHHS) most vulnerable patients, because of the often-complex nature of their health conditions, but also because they are often discharged into very difficult circumstances. Many are patients without social supports, who do not have access to adequate food, shelter, or a safe place to even store medications – let alone focus on recovery. These circumstances lead to a significantly higher risk of readmission and a poorer quality of life for them.

Led by SCVHHS and its Homeless Healthcare Advisory Board, the Santa Clara Medical Respite Program is a unique public-private collaborative, which also includes eight area hospitals and a homeless shelter. The Medical Respite Program provides homeless patients recently discharged from the hospital access to a 20-bed facility that provides a safe, clean environment for recuperation from hospitalization. All referred patients at the MRP receive comprehensive health and psychosocial assessments that allow for individualized plans and services to help link the homeless patients with comprehensive primary care in a health home, specialty care, entitled benefits, substance abuse and mental health treatment, and other needed supports and services.

The program has had 1,800 referrals and has welcomed 700 patients since its inception, and has led to an estimated reduction of 2,488 bed days and a cost savings of over $6 million. Among the Medical Respite Program's patients, the 30-day readmission rate is 18%, compared to the average rate of 50% for homeless patients. But the patients themselves tell the story even better:

"Without the opportunity to stay at the Medical Respite Center, I probably would not have survived during the month of November. (This program is) saving the lives of people on the street and treating us with respect...I am no longer Willie the homeless guy. I am citizen Willie."

"It's time to give back to the community, and I thank respite for giving me that opportunity."

DATA-DRIVEN ORGANIZATION AWARD

San Francisco Health Network

Improving Specialty Care Access in a Safety Net System: Assessment, Engagement, and Innovation

It's not easy to collect accurate data. All health systems know this, and work hard to improve their data collection policies, procedures, and practices. It's even harder to do something productive with that data once you've got it. San Francisco Health Network knew that access to specialized care was a problem for many of its patients, and knew that the solution would require both collecting new data, and just as importantly, analyzing and acting upon it.

SFHN embarked on a two-year project aimed at figuring out how to address disparities in access to care and streamline specialty care delivery.

The first step was a needs assessment and gap analysis, which included the collection of baseline data, as well as interviews with leadership and focus groups with patients. A team of physicians and nurses then developed a method for collecting, analyzing and tracking data across specialty care clinics, based on the needs that had been identified. New quality and operational dashboards were created for all 26 specialty clinics to highlight patient satisfaction and quality metrics, with a focus on "third next available appointment" (TNAA) data, one of the industry standards for measuring access. Once these dashboards were in place and being utilized, the data started coming in, and the performance improvement work could be developed based on the analysis of that data.

This performance improvement work has included (but has not been limited to) the expansion of clinics, the use of non-physicians to evaluate patients, improving efficiencies through workplace organization, the utilization of group classes for patients, and collaboration with outside hospitals to perform the backlog of diagnostic procedures.

The results of this work on the system's specialty care TNAA numbers have been staggering. Before the project, almost one quarter of clinics had a TNAA of more than 120 days. Now that number is less than 3%. At the other end of the spectrum, at the outset of the project only 14% of clinics had a TNAA of fewer than 15 days. Now it's nearly half. And thanks to a continued emphasis on collecting and analyzing data, these numbers will keep improving.

ADVANCED PRIMARY CARE AWARD

Ventura County Health Care Agency
Innovative Diabetes Care with Group Medical Care

We use the phrase “advanced primary care” to describe systems that provide “right place, right time care,” especially for those with chronic conditions. Ventura County Health Care Agency, as part of its work under the Delivery System Reform Incentive Program (DSRIP), created a remarkable program at Las Islas Diabetes Center in South Oxnard.

The clinical teams at Las Islas had the goal of creating a “one-stop shop” approach for their patients in group visits. They started by finding and fixing gaps in the retinal screening workflow, then implemented comprehensive group visits that included a foot exam, blood draw and dietician education.

But these visits offer more than just convenient access to services. Effective diabetes care relies heavily, if not mostly, on a patient’s ability and willingness to care for themselves. These classes have empowered patients with the tools and social supports to help manage their own conditions.

“I actually have recommended the classes to friends,” says Linda Villegas, a patient at VCHCA. Linda had just been diagnosed with diabetes upon starting the group visits, so hearing about other patients’ experiences with their diabetes really helped. “Patients are encouraged to come together and socialize with the goal that they will offer support to one another,” says Karla Alcaraz, RN, CDE, the case manager who organizes group visits. “Many maintain friendships beyond the scope of the class.”

Alcaraz says the programs are showing incredible results. Three quarters of patients who were not at their LDL goal when starting the class did get to an LDL less than 100 upon completion. More than half of patients who were not at their A1c goal achieved an A1c less than 7, or at least a 1-point drop. Some patients have lowered HbA1c by more than 2 points over the course of these visits, and several have lost 15 to 20 pounds.

“The classes put you on track to manage and improve self-care,” says Villegas.