CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

PRIME REQUIRED PROJECT IMPLEMENTATION WEBINAR

Webinar Series 2: Successful Approaches to Disease Management and Screening

Diabetes Control: Operational Practices and Resources

Thursday, February 16, 2017; 12:00-1:00pm

Recording Link:
https://safetynetinstitute.webex.com/safetynetinstitute/lsr.php?RCID=e107ecdca4164d1b98c3ba0fb8d00cd3

Agenda

Time	Topic	Lead(s)
12:00-12:05	**Opening** PHS background on metric	David Lown, MD Chief Medical Officer, SNI
12:05-12:55	Diabetes Control: Operational Practices and Resources Q&A	Theresa Cho, MD, Quality Medical Director for Ambulatory Care, Ventura County Medical Center Cassie Morn, MD, Medical Director, UCSD Scripps Ranch Clinic UCSD; DM Champion for UCSD Medi-Cal P4P Committee and UCSD Clinically Integrated Network
12:55-1:00	**Resources** **Closing**	David Lown, MD

Housekeeping

Please mute locally

At any time, feel free to chat your question & we will read out

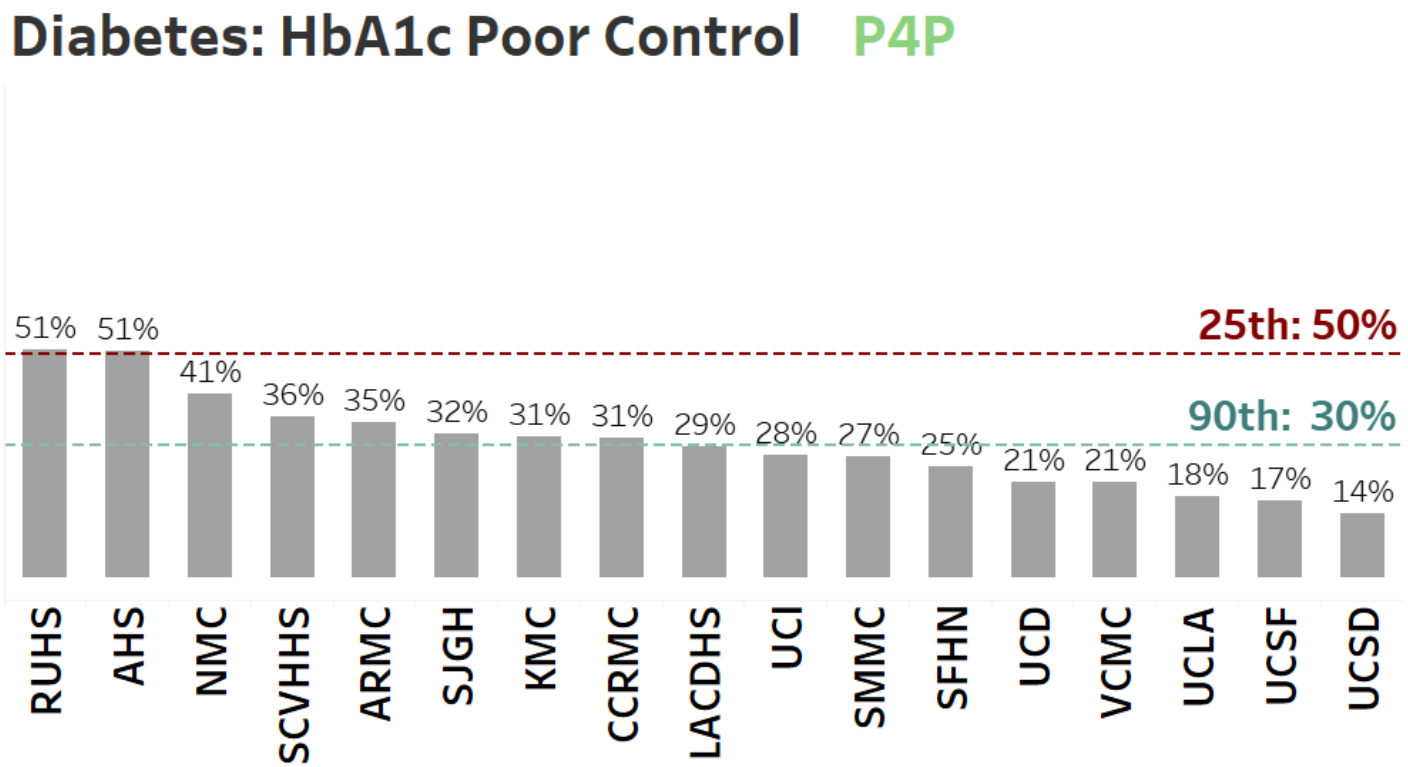
Webinar will be recorded

Deck & tools will be saved on [SNI Link]

CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

PHS Performance
Diabetes: HbA1c Poor Control
Metrics 1.1.3 & 1.2.4



CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

Data as of 11/30/16

Not approved by DHCS

VENTURA COUNTY
AMBULATORY CARE

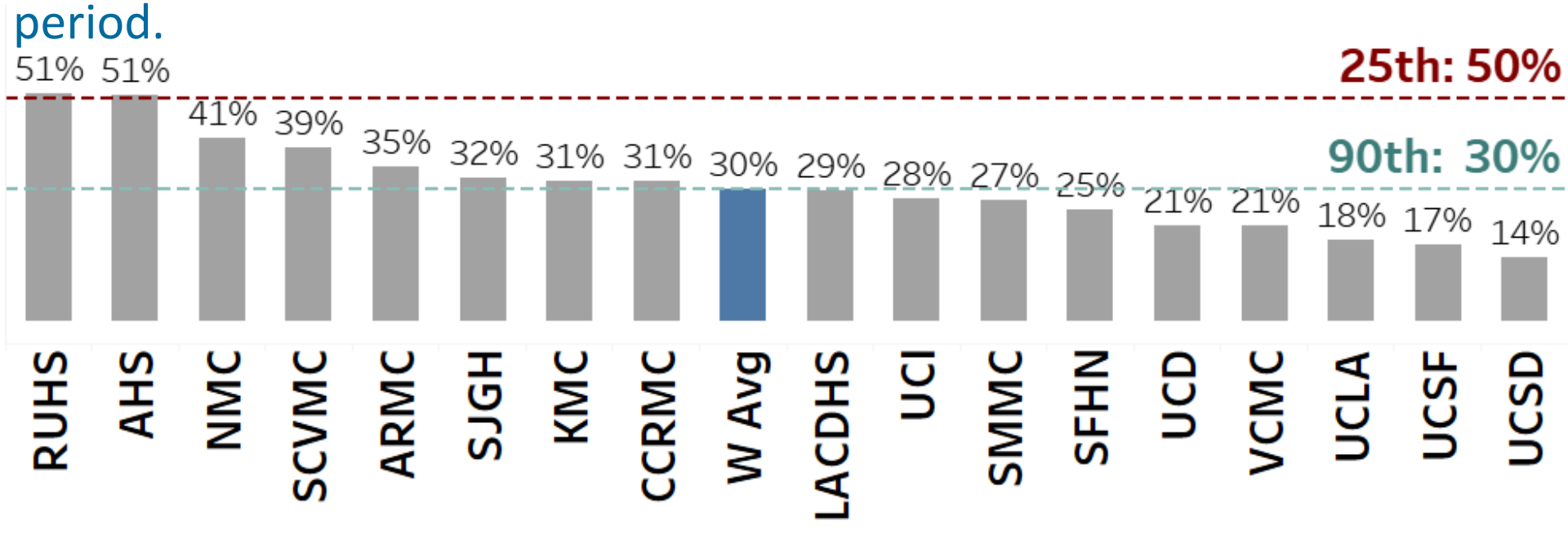
DIABETES CONTROL: OPERATIONAL PRACTICES AND RESOURCES

Theresa Cho, MD
Medical Director, Ambulatory Care Quality
Director, Las Islas Diabetes Center
February 16, 2017

PRIME 1.1.3 and 1.2.4: Diabetes HbA1c Poor Control

Numerator: Patients whose most recent HbA1c level is greater than 9.0% or is missing a result, or for whom an HbA1c test was not done during the measurement period.

Denominator: Patients 18-75 years of age by the end of the measurement period who had a diagnosis of diabetes (type 1 or type 2) during the measurement period or the year prior to the measurement period.



Road to Success

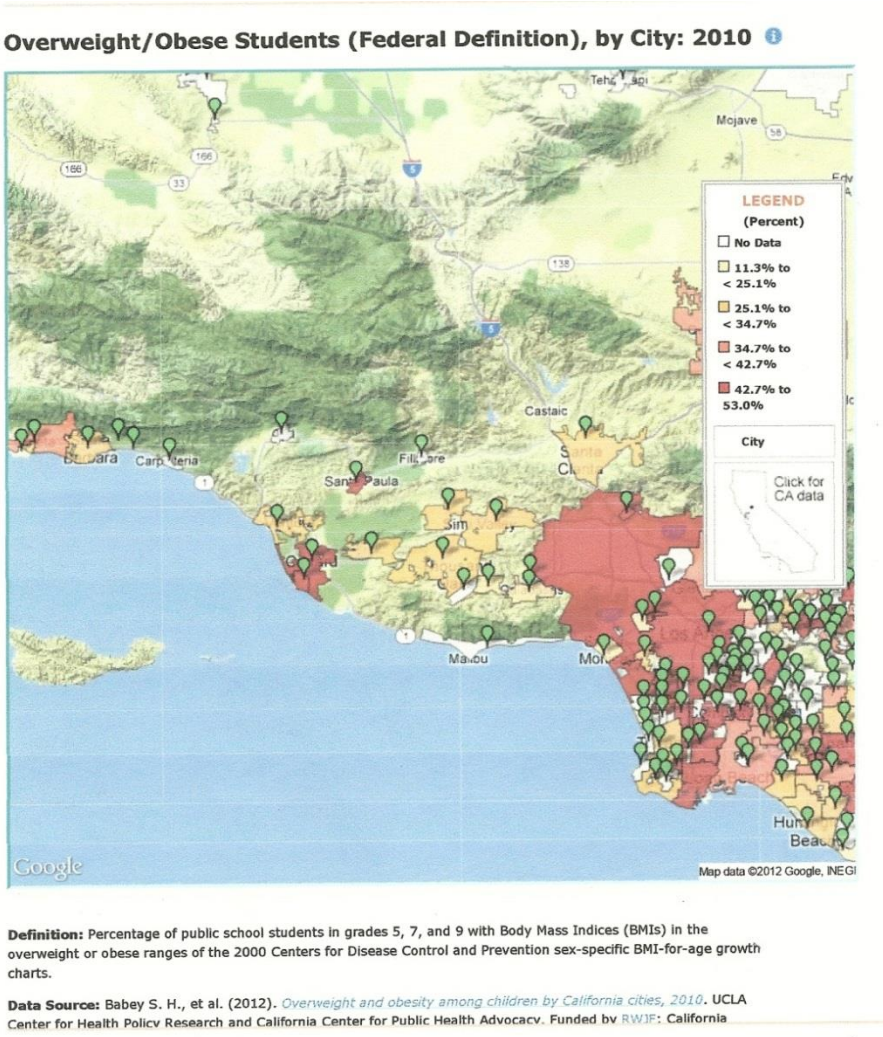
1. Development of a comprehensive diabetes center
2. Community outreach efforts
3. Performance improvement projects
4. Collaboration with colleagues

Diabetes and Population Health

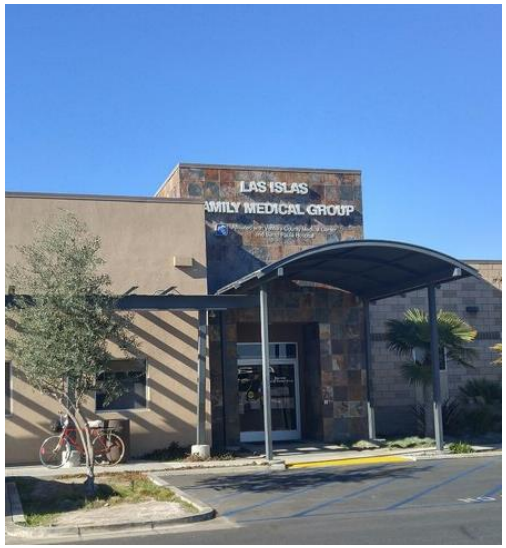
- According to a March 2016 study from the UCLA Center for Health Policy Research, 7% of Ventura County adults have diabetes.
- Additionally, 47% of Ventura County adults have pre-diabetes.

In Ventura County:

- Port Hueneme ranked 2nd highest in California for childhood obesity (52.6%).
- Oxnard ranked 21st (47.9%).
- Santa Paula ranked 22nd (47.9%).



Las Islas Diabetes Center



Opened in 2010 to address the needs of patients with diabetes in South Oxnard and throughout Ventura County.

Our team includes:

- Physician
- Nurse Care Manager
- Registered Dietitian/Certified Diabetes Educator
- Psychologist
- Social worker
- Medical Assistant

Types of Care Provided

- Adult diabetes
- Pediatric diabetes
- Gestational diabetes
- Diabetic foot and wound care
- Retinal screening
- Nutrition and self-management education
- Peri-operative diabetes care

Types of Care Provided (continued)

- Group education and medical visits in Spanish and English
- Diabetes and depression group therapy
- Device management including insulin pumps and continuous glucose monitors
- Community outreach

Education Recognition Program: ADA

DiabetesPro℠
Professional Resources Online

All types | Search

Clinical Corner | Diabetes Educators | Research & Grants | Continuing Education | Membership | Scientific Sessions

ERP Listing

Search Recognized Education Programs by zip code or filter by state.

Search

Enter a search area and zip code and click apply to search.

25 Miles | from 93033 | Apply | Reset

▸ Show/Hide Map

Sponsoring Organization: Un Dulce Comienzo (A Sweet Start)
Site/Program Name: Ventura County Medical Center
Program ID: 6084
Address: 325 West Channel Islands Blvd
City: Oxnard
State: California
ZIP: 93033
Phone: 805-486-2145
Spanish: Yes
Pediatric: No
Long-Distance Learning: No
Distance 3.20 miles
Driving Directions

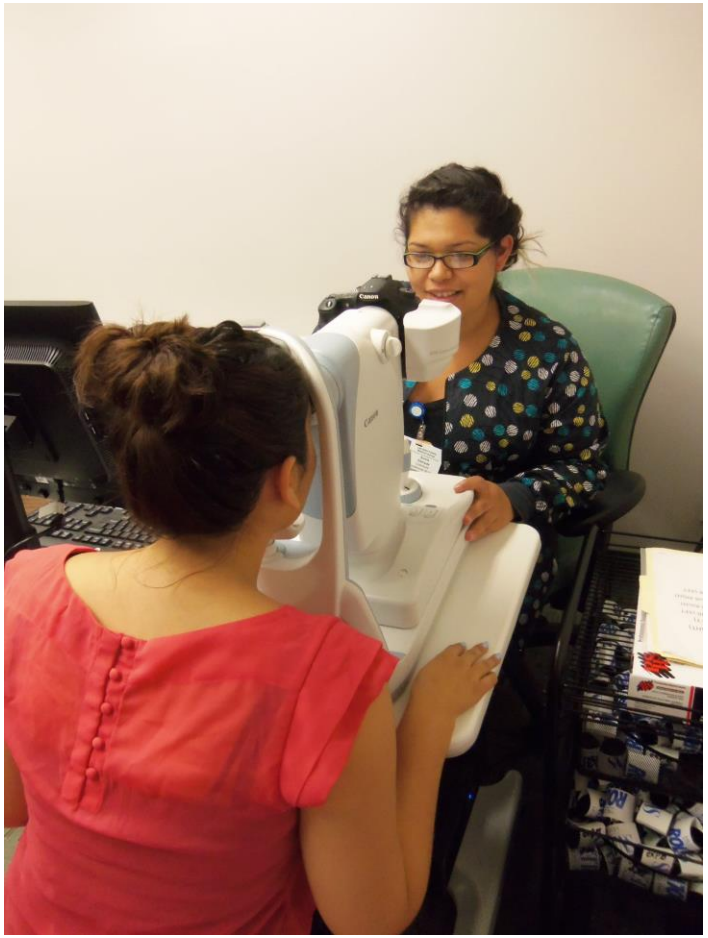
Community Outreach

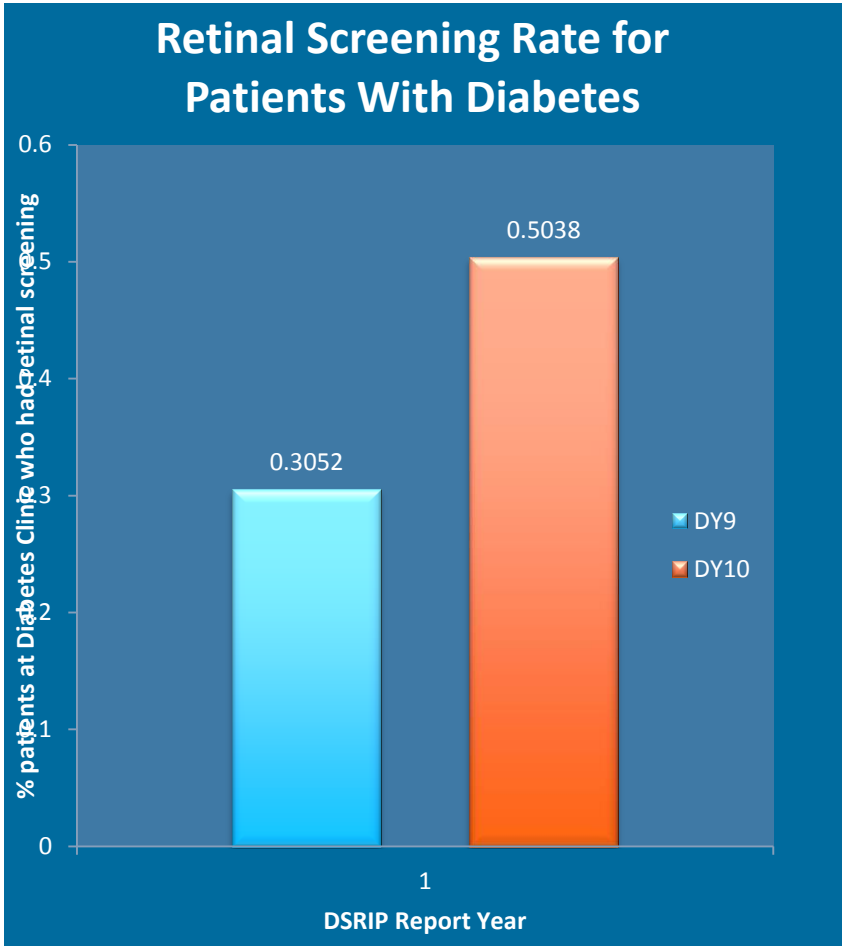
American Diabetes Association (ADA)

Mixteco Indígena Community Organizing Project (MICOP)

Lions Club

DSRIP Data: Retinal Screening

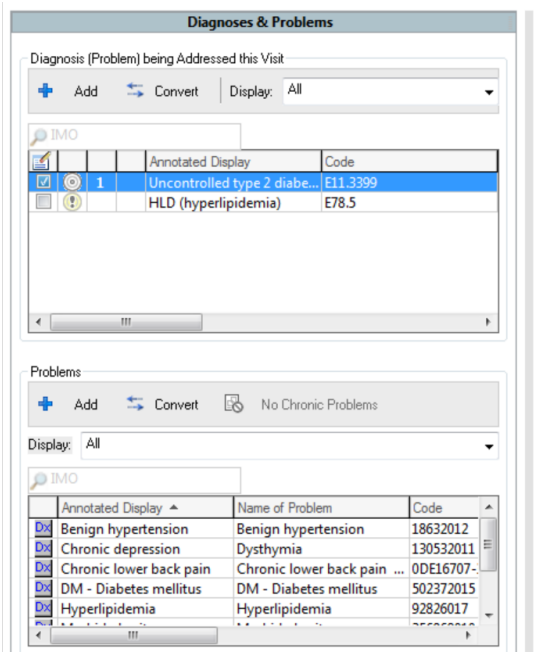


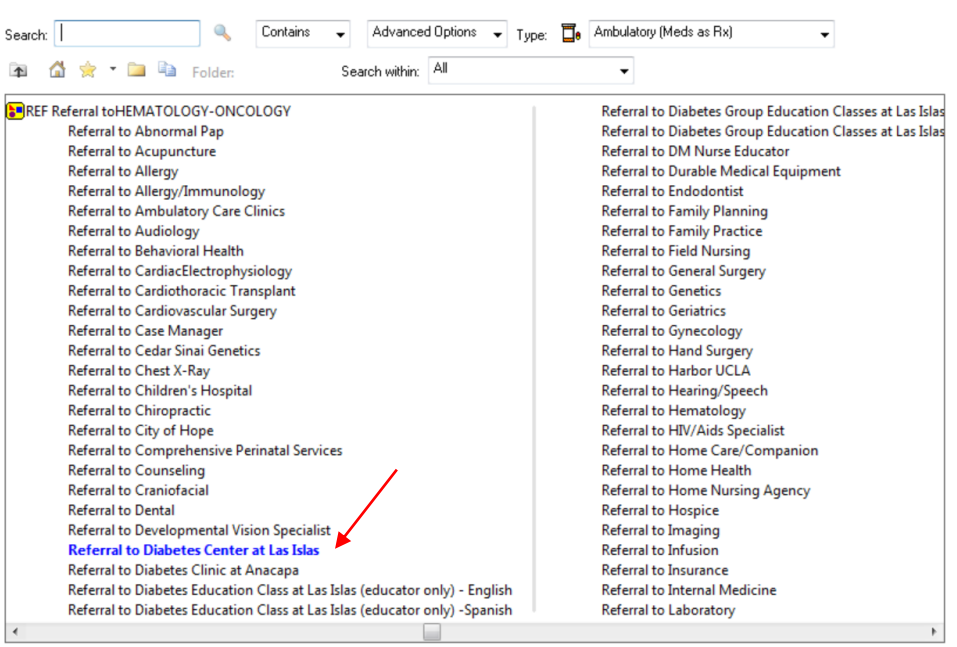


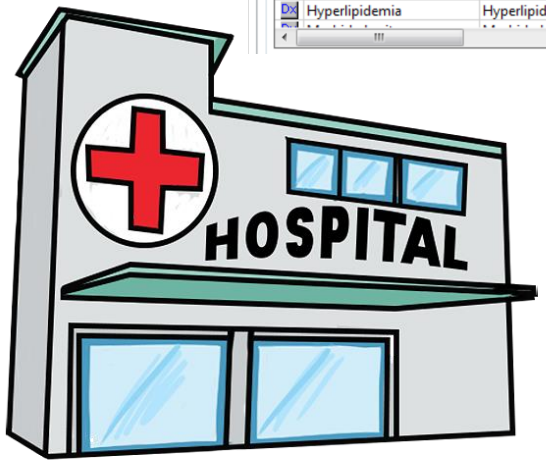
Medical Team Engagement

1. Partnerships with other primary care physicians and specialists
2. Transition of care between hospitals and clinics
3. Sharing a common goal to improve care
4. Leadership buy-in, specialist buy-in (poor outcomes, bad press, lost revenue)
5. Accountability
6. Sharing best practices: ACQA, CME lectures

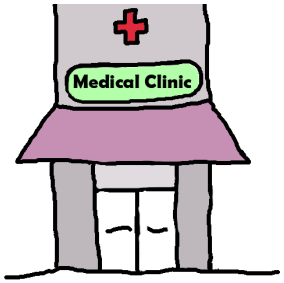
Transitions







Diabetes Center

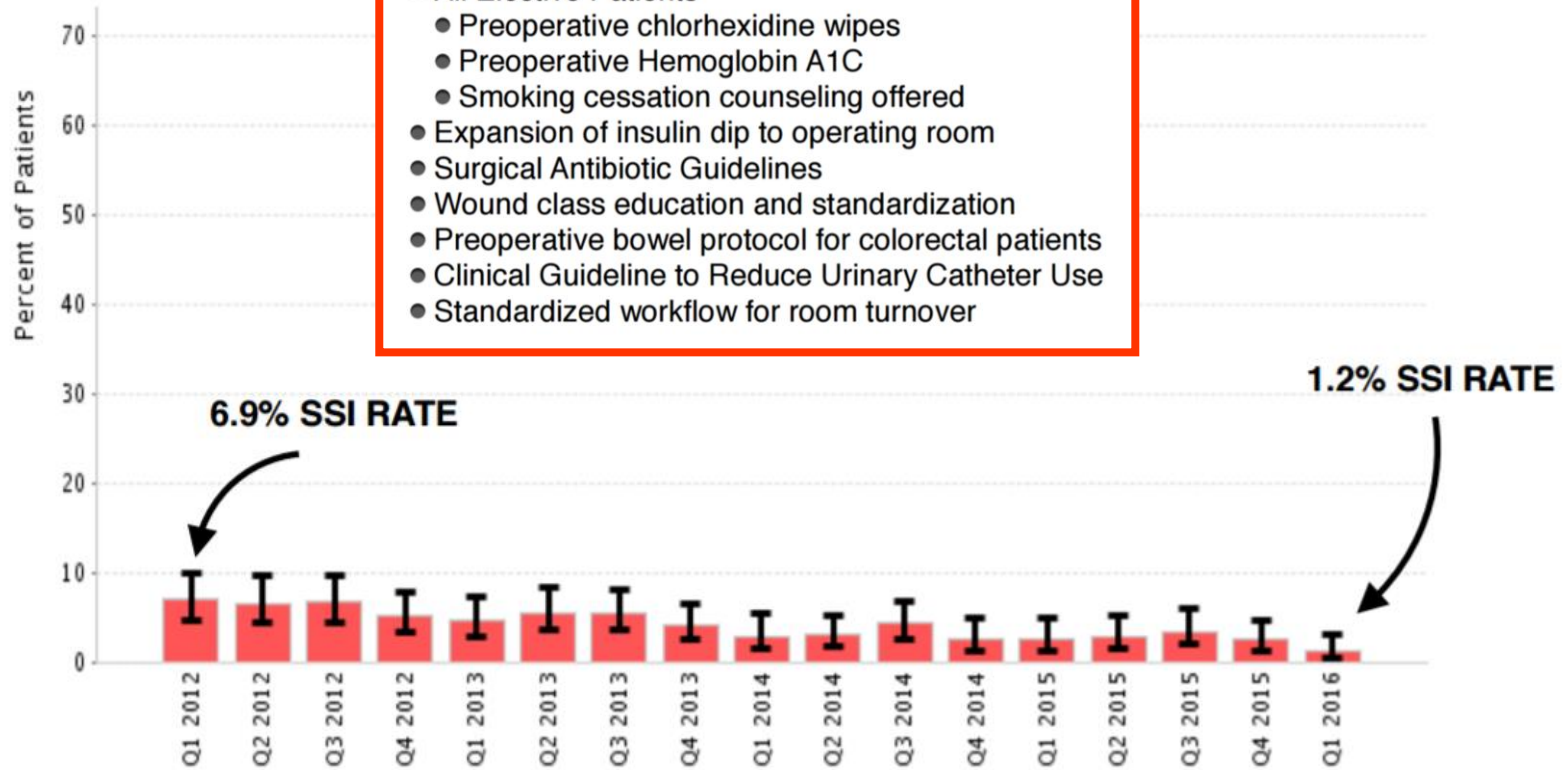


Engagement and Collaboration

VCMC SURGICAL SITE INFECTION REDUCTION

Quality Improvement Accomplishments:

- All Elective Patients
  - Preoperative chlorhexidine wipes
  - Preoperative Hemoglobin A1C
  - Smoking cessation counseling offered
- Expansion of insulin dip to operating room
- Surgical Antibiotic Guidelines
- Wound class education and standardization
- Preoperative bowel protocol for colorectal patients
- Clinical Guideline to Reduce Urinary Catheter Use
- Standardized workflow for room turnover



Diabetes and SSI improvement

1. Clear incentive
2. Clinically actionable
3. Measurable outcome
4. Consistent evidence-based goal
5. Data

Collaboration with Stakeholders

April 7, 2014

Dear Colleague,

In collaboration with the Armstrong Institute for Patient Safety, our performance improvement and surgical departments have launched an initiative to reduce the incidence of surgical site infections (SSI) in colorectal surgery patients at VCMC and SPH. Our collaborative has identified opportunities for improvement in two major risk factors: poor glycemic control and tobacco use. We are writing to solicit your help in reducing our patients' preoperative risk of SSI.

Prior to referring a patient to Anacapa Surgery for an elective operation, please complete the following:

1. For patients **with diabetes**, ensure documentation of the patient's **glycohemoglobin** within the last **3 months**.
2. For adult patients **without diabetes**, ensure documentation of the patient's **glycohemoglobin** within the last **12 months** (to confirm that the patient has been screened to rule out diabetes).
3. Document the most recent date that the physician counseled the patient regarding **tobacco cessation**. Counseling should have been done within the last 3 months for patients who smoke. Please enter the counseling **date** under Histories, in the Social History tab, by double-clicking the Tobacco category.

Prior to the patient's pre-operative appointment, the office staff at Anacapa will review the patient's record to confirm that the referring provider has addressed the above issues. A communication will be sent to the PCP regarding missing glycohemoglobin and tobacco information, and if these remain incomplete at the pre-operative visit, the surgeon will order the glycohemoglobin and tobacco counseling at Anacapa.

Please keep in mind that a patient with poorly-controlled diabetes and a glycohemoglobin ≥8% has a significantly higher risk for SSI and other surgical complications. When possible, surgery referral should be delayed until glycemic management has improved. If you feel that a multi-disciplinary approach to DM management (including diabetes physician, dietitian, psychologist, and nurse educator) would benefit your patient, please make a referral to the Las Islas Diabetes Center.

Patients who use tobacco may call (805) 201-STOP (201-7867) for Ventura County Public Heath's free "Call it Quits" classes. They may also get assistance with a tobacco cessation plan by calling the California Smoker's Helpline at 1-800-NO-BUTTS (English) or 1-800-45-NO-FUME (Spanish). In addition, the surgery clinic will reinforce your efforts by offering smoking cessation counseling by trained staff at the time of initial surgical consultation.

Thank you for your efforts to help us improve patient care by reducing surgical site infection rates at VCMC and SPH.

Respectfully,

Jeremy Schweitzer, MD
Anacapa Surgical Associates

Theresa Cho, MD
Las Islas Diabetes Center

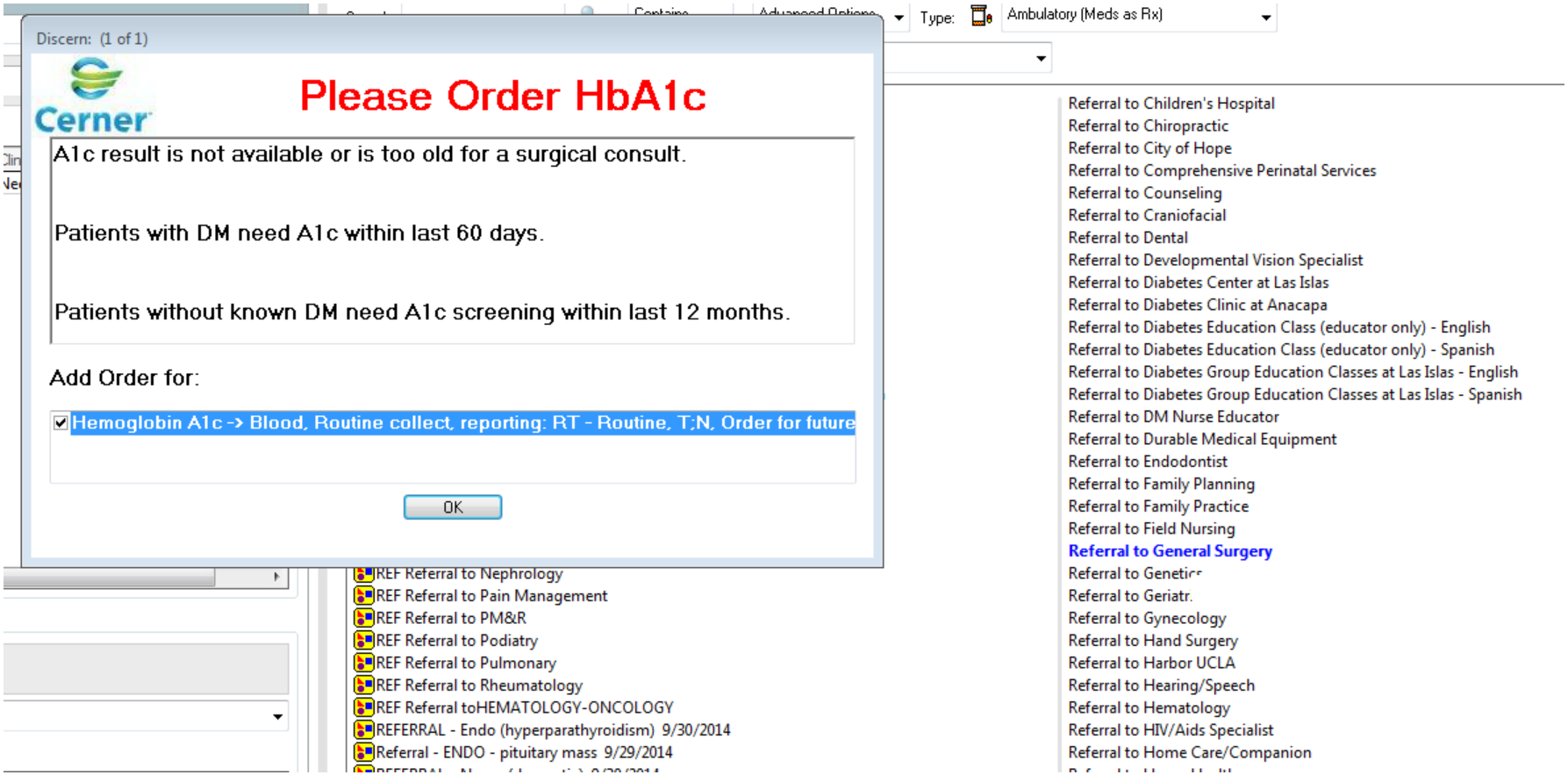
Rick Rutherford, MD
Director, Performance Improvement

Bryan Wong, MD
VCMC/SPH Medical Director

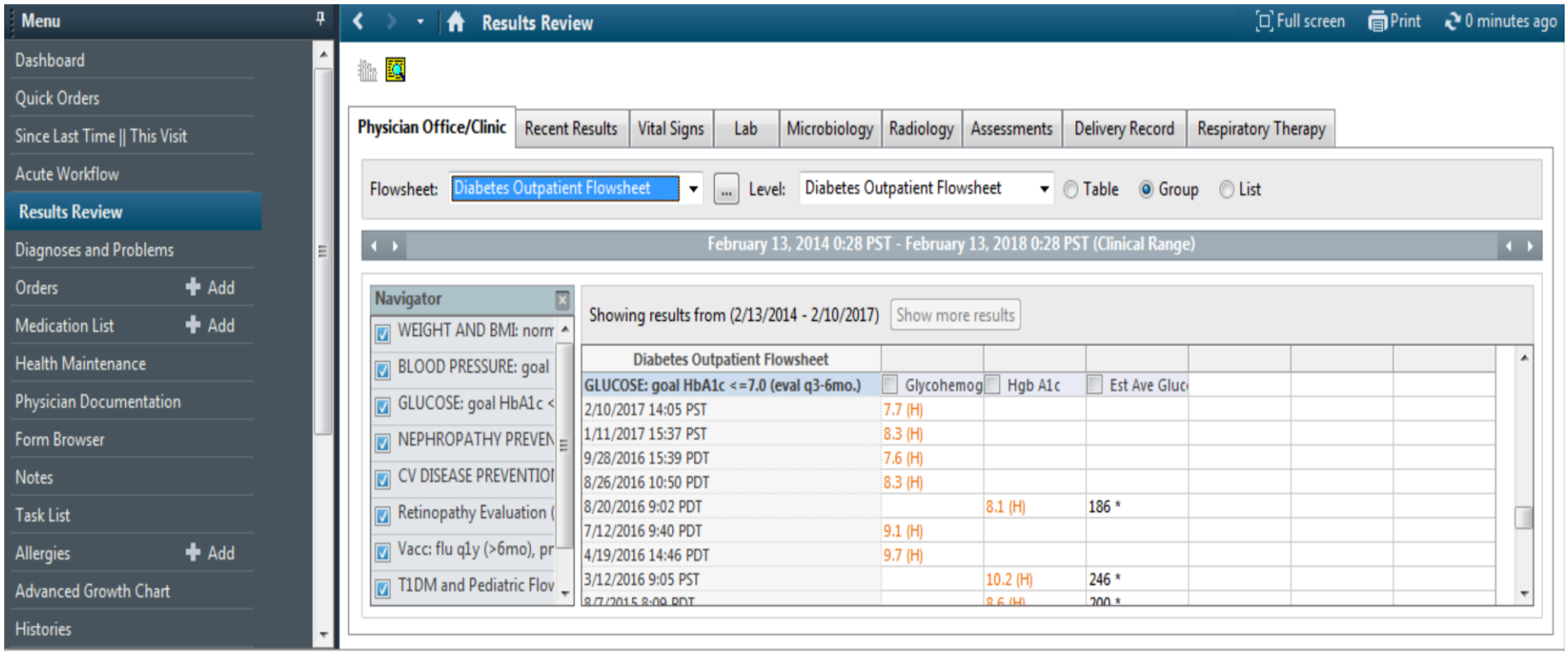
Surgery and Diabetes

- Referrals to surgery screened by surgery staff
- Automatic referral into Diabetes Clinic
- Diabetes Clinic within Surgery Clinic

EHR Tools to Improve Care: Automated Reminders



EHR Tools to Improve Care: Diabetes Flowsheet



EHR Tools to Improve Care: Importing Select Data into Note

General: Well-developed, well-nourished woman, in NAD
HEENT: NCAT, PERRL, EOMI, conjunctiva clear, intact dentition, oral mucous membranes moist
Cardiovascular: RRR, normal S1 and S2, no murmurs, rubs, or gallops
Lungs: clear to auscultation bilaterally, no wheezes, rales, or rhonchi
Abdomen: NABS, soft, NT, ND, no organomegaly, no masses
Extremities: no CCE

Lab Results

Diabetes Results (Last charted value.)

A1c	H 8.1	(08/20/16)
A1c-POC	H 7.7	(02/10/17)
GluPOC	103	(02/10/17)
Cr	0.98	(08/20/16)
mAlb/Cr	H 87.8	(01/10/14)
GFR	>60.0	(08/20/16)
TSH	1.901	(08/20/16)
Trig	153	(08/20/16)
Chol	136	(08/20/16)
HDL	L 25	(08/20/16)
LDL	95	(08/20/16)
Eval Retinopathy	Yes - Retinal scan done ONLY	(03/30/16)
Retin Date	03/12/16	(03/30/16)
Retinopathy Results	No Apparent Diabetic Retinopathy	(03/30/16)
Influenza	0	(09/01/16)
PCV-23	0.5 mL	(08/09/16)

Assessment/Plan

BMI 45.0-49.9, adult

Elevated BMI noted. I reviewed BMI goal with patient and advised lifestyle changes, including dietary modification and increased physical activity, for weight management.

Diabetes type 2, uncontrolled

I spent over 25 minutes with the patient today, with over 50% of that time counseling the patient about diabetes management, reviewing medications, discussing weight management, and diminished libido.

1. Continue metformin at her 500 mg XR once a day. Unable to increase dose due to history of GI intolerance.
2. Continue Victoza 1.8 mg subcutaneous daily
3. Continue Toujeo 25 units subcutaneous nightly

Resources

- Information for Patients and Health Care Providers

  http://diabetes.org/

- American Diabetes Association Standards of Medical Care in Diabetes—2017

  http://professional.diabetes.org/sites/professional.diabetes.org/files/media/dc_40_s1_final.pdf

- Group Education Material

  http://healthyinteractions.com/assets/files/HI_PositionPaper_v01_16_102715.pdf

- Ventura County Preoperative Management Policy
  https://safetynetinstitute.org/wp-content/uploads/2016/05/preop-management-of-elective-surgery-patients-policy-0916.pdf

UC San Diego Health

Implementing Diabetes Quality Care

CASSIE MORN, MD

UCSD DEPARTMENT OF FAMILY MEDICINE

The Plan: Diabetes Protocol

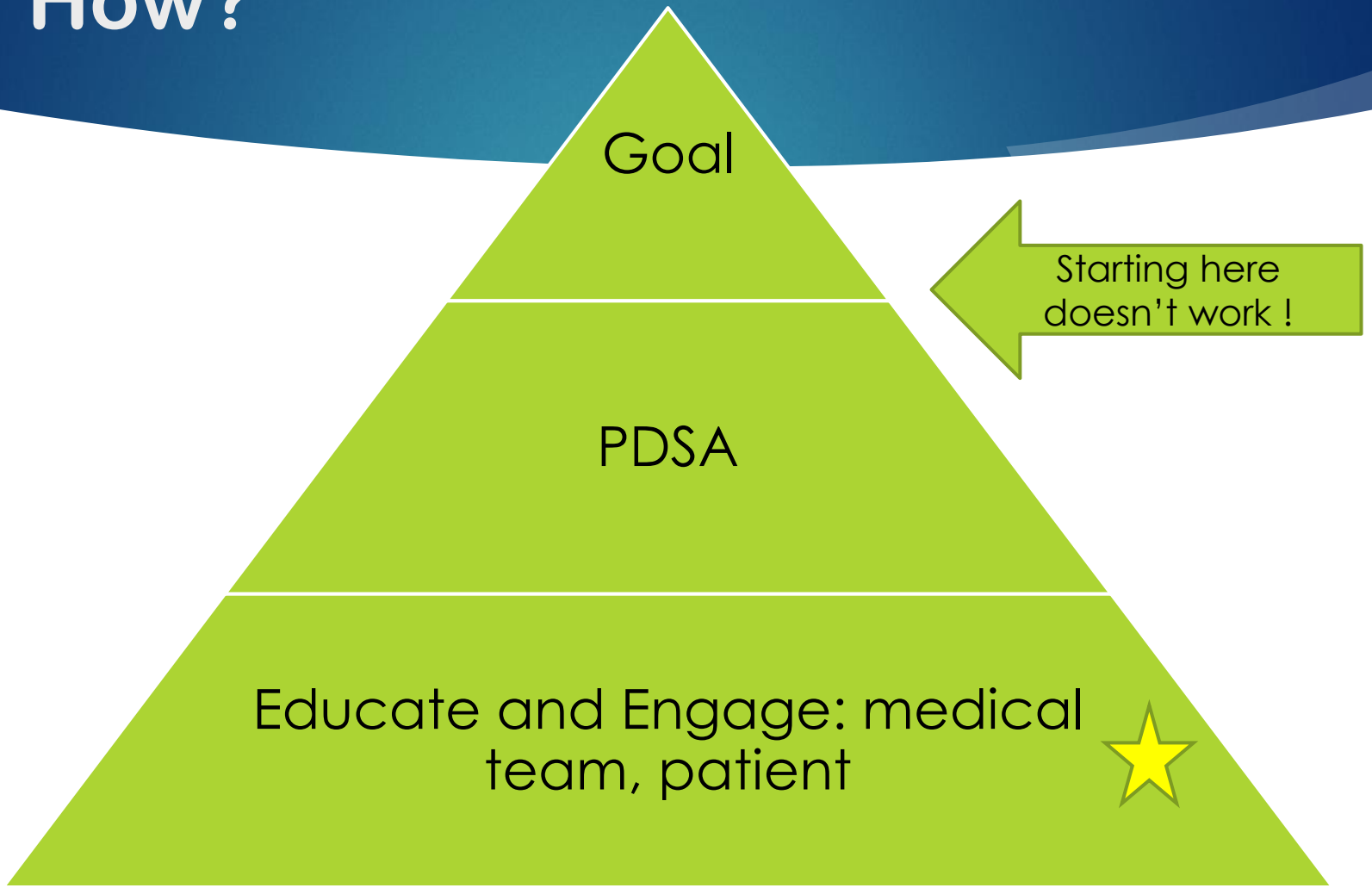
Provide high quality care to all patients diagnosed with Diabetes

-ADA Standards of Care (EBM)

-Integrated Healthcare Association (IHA) 90th percentile

Two A1cs per year	A1c control <8.0	A1c poorly controlled A1c >9.0	Annual Nephropathy screening	Blood Pressure Control	Annual foot exam	Annual retina exam

How?


Goal
PDSA
Educate and Engage: medical team, patient
Starting here doesn't work !

Engage

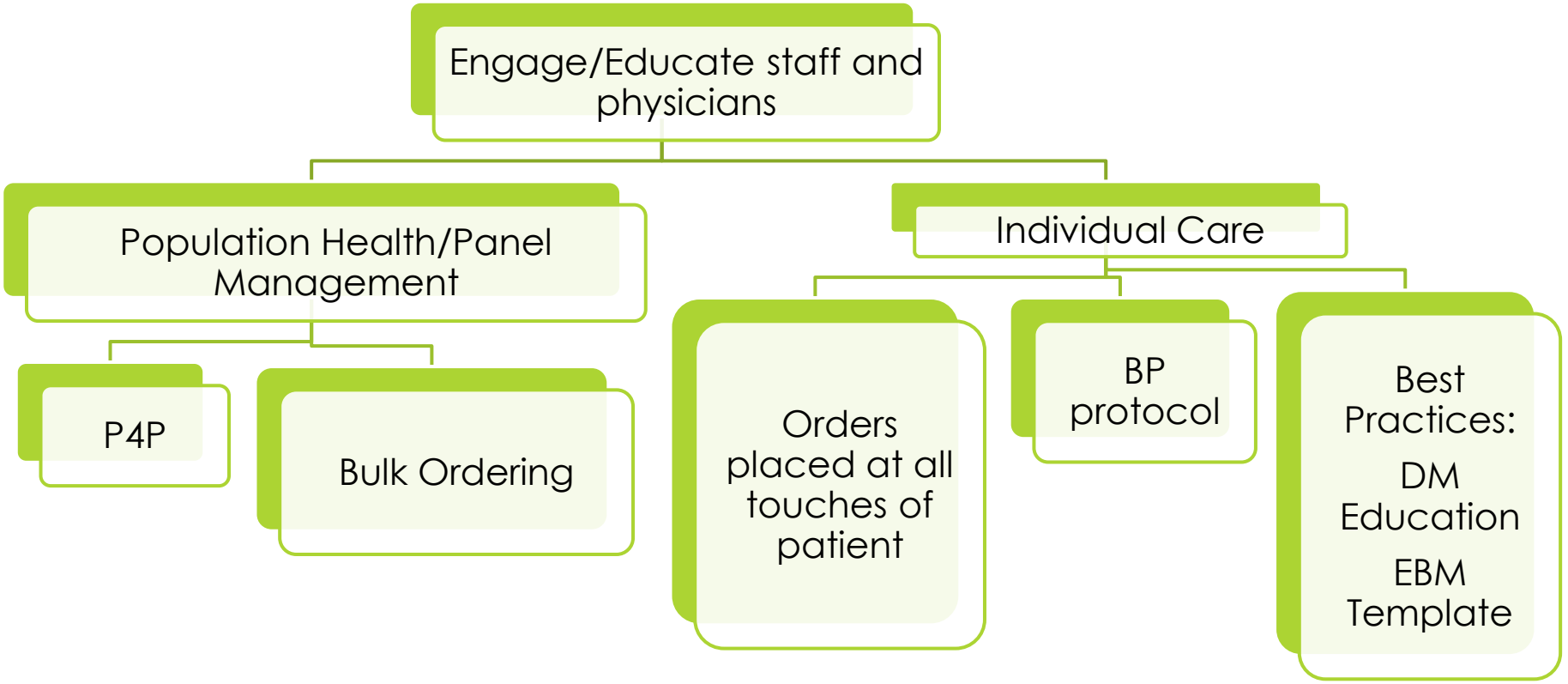
Staff

- Team approach/patient ownership
- Staff committee
- Incentive payments
- Team competition

Physician

- Decreased work load
- Incentive payments
- Transparency of data/feedback
- Educational

Overview


Engage/Educate staff and physicians
Population Health/Panel Management
P4P
Bulk Ordering
Individual Care
Orders placed at all touches of patient
BP protocol
Best Practices:
DM Education
EBM Template

Do…Population Outreach

*Outreach done monthly

Managed Care

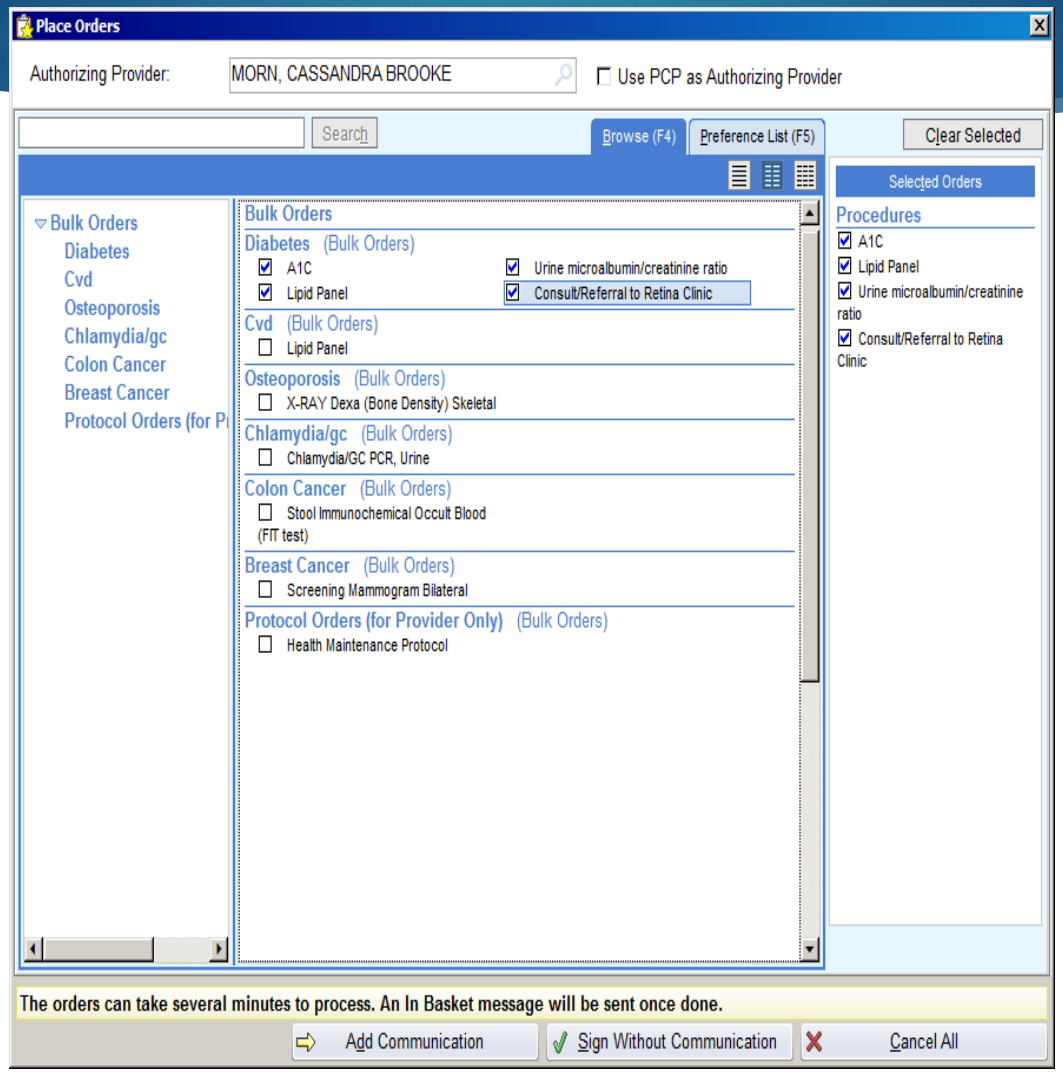
- P4P list
- Televox
- Home blood draws

All Payors

- EMR Bulk Ordering

UC San Diego Health

Bulk Ordering



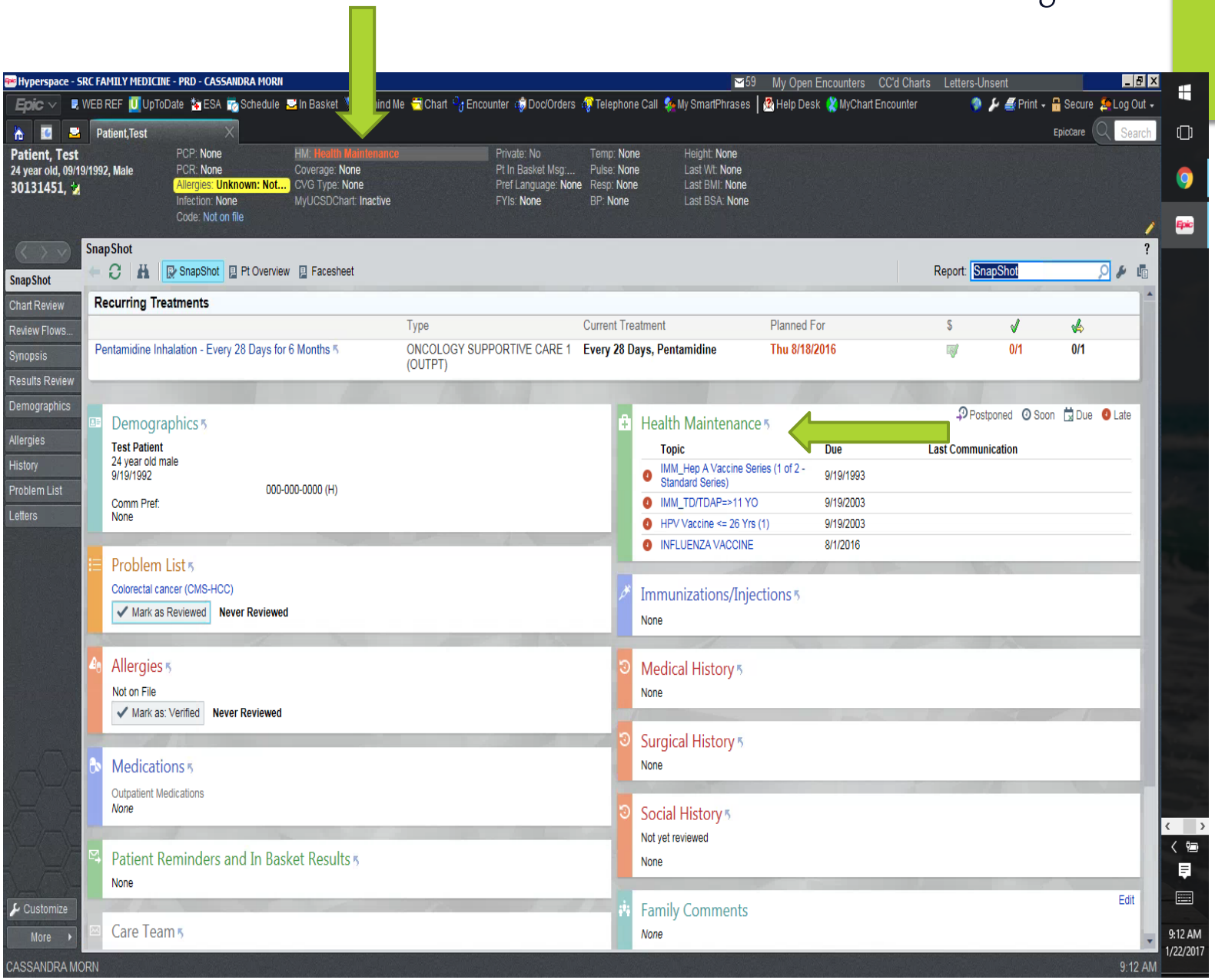
Do…Individual Care

Don't miss opportunities

- Pre-visit encounter (huddle)
- all patient touches
  - For all refills, telephone encounters, mychart messages and acute visits: HM button reviewed and orders placed

Guideline based care

- BP protocol
- EMR template
  - Note prompts for ADA guideline based care
  - Orders accessible


Hyperspace - SRC FAMILY MEDICINE - PRD - CASSANDRA MORN
My Open Encounters
CC'd Charts
Letters-Unsent
WEB REF
UpToDate
ESA
Schedule
In Basket
Chart
Encounter
Doc/Orders
Telephone Call
My SmartPhrases
Help Desk
MyChart Encounter
Print
Secure
Log Out
Patient,Test
Search
Patient, Test
24 year old, 09/19/1992, Male
30131451,
PCP: None
PCR: None
Allergies: Unknown: Not...
Infection: None
Code: Not on file
HM: Health Maintenance
Coverage: None
CVG Type: None
MyUCSDChart: Inactive
Private: No
Pt In Basket Msg:...
Pref Language: None
FYIs: None
Temp: None
Pulse: None
Resp: None
BP: None
Height: None
Last Wt: None
Last BMI: None
Last BSA: None
SnapShot
Chart Review
Review Flows...
Synopsis
Results Review
Demographics
Allergies
History
Problem List
Letters
Customize
More
SnapShot
Pt Overview
Facesheet
Report: SnapShot
Recurring Treatments
Type
Current Treatment
Planned For
$
Pentamidine Inhalation - Every 28 Days for 6 Months
ONCOLOGY SUPPORTIVE CARE 1 (OUTPT)
Every 28 Days, Pentamidine
Thu 8/18/2016
0/1
0/1
Demographics
Test Patient
24 year old male
9/19/1992
000-000-0000 (H)
Comm Pref:
None
Problem List
Colorectal cancer (CMS-HCC)
Mark as Reviewed
Never Reviewed
Allergies
Not on File
Mark as: Verified
Never Reviewed
Medications
Outpatient Medications
None
Patient Reminders and In Basket Results
None
Care Team
Health Maintenance
Postponed
Soon
Due
Late
Topic
Due
Last Communication
IMM_Hep A Vaccine Series (1 of 2 - Standard Series)
9/19/1993
IMM_TD/TDAP=>11 YO
9/19/2003
HPV Vaccine <= 26 Yrs (1)
9/19/2003
INFLUENZA VACCINE
8/1/2016
Immunizations/Injections
None
Medical History
None
Surgical History
None
Social History
Not yet reviewed
None
Family Comments
Edit
None
CASSANDRA MORN
9:12 AM
9:12 AM
1/22/2017

UC San Diego Health

All Touches…Refill request (smartphrase: .rxr)

Patient is requesting refill of Metformin 1,000 mg
Last refill: 11/3/15
Pharmacy: CVS Westview Pkway
Last visit in this department 11/7/2016
Next visit in this department Visit date not found

Last labs:

Lab Results

Component	Value	Date
CHOL	182	11/07/2016
HDL	43	11/07/2016
LDLCALC	118	11/07/2016
TRIG	106	11/07/2016
LDLDIRECT	125	03/01/2010
TSH	1.93	03/29/2011
TSH	2.64	01/10/2006
A1C	8.4	10/17/2016

-staff driven phrase
-Decreased work load

Blood Pressure

11/07/16	120/80
06/06/16	151/87
05/09/16	139/82

HM Items that are overdue or due soon include:

Health Maintenance Due

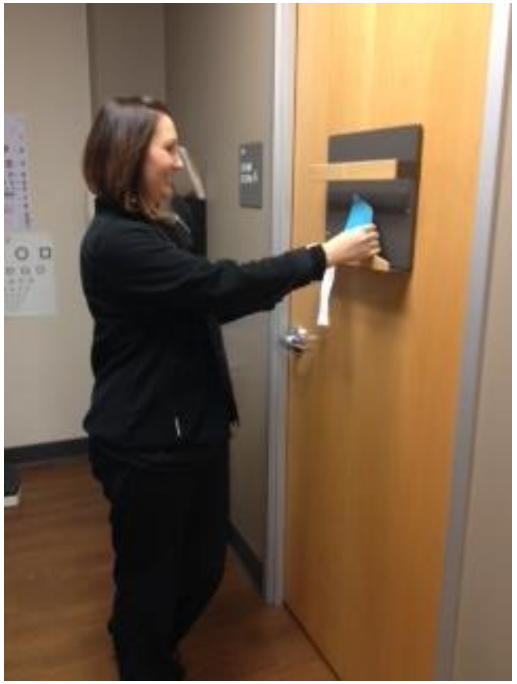
Topic	Date Due
• DM_RETINA EXAM	12/17/2015

UC San Diego Health

Blood Pressure Protocol

BP Control: Blue Card Protocol

- All BP readings >139/89 blue card put on door
  - Alerts doctor
  - Reminds MA to repeat
- Repeat BP at end of visit
  - MA/nurse competency completed
- Nurse visit 1 week for BP check



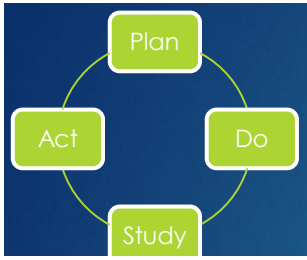
A1c Control

-A1c controlled (< 8.0)

-A1c poorly controlled (> 9.0)

- Refer to DM education classes
  - At diagnosis
  - Poorly controlled
  - Consider annually
- Refer to PharmD intensive medication management
  - Pro-active calling patients with A1c>9.0
- Increase frequency of physician visits
- Use of DM template to assist with standard of care
- Econsults to Endocrinology

UC San Diego Health



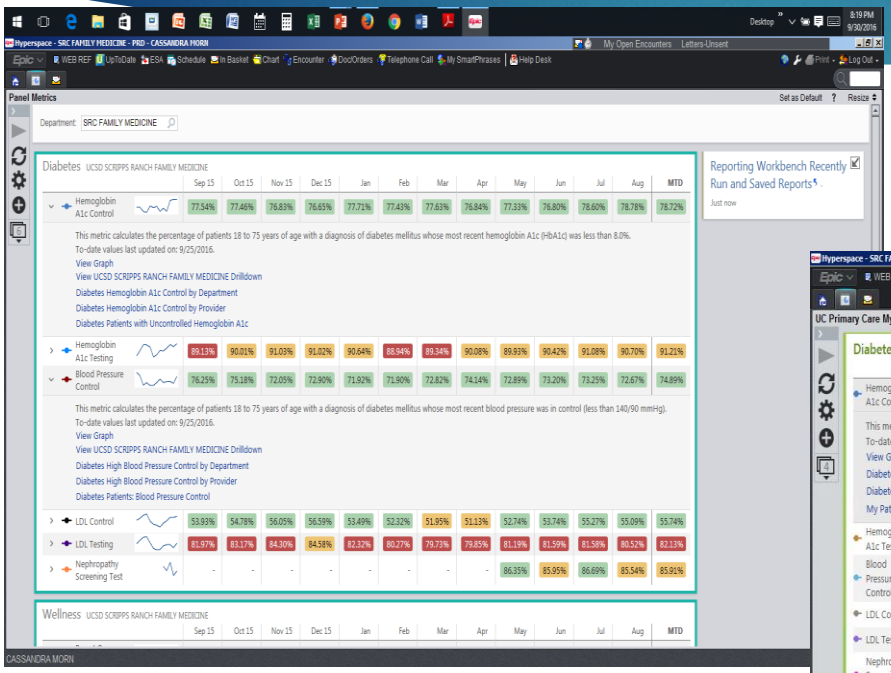
Study: P4P Report

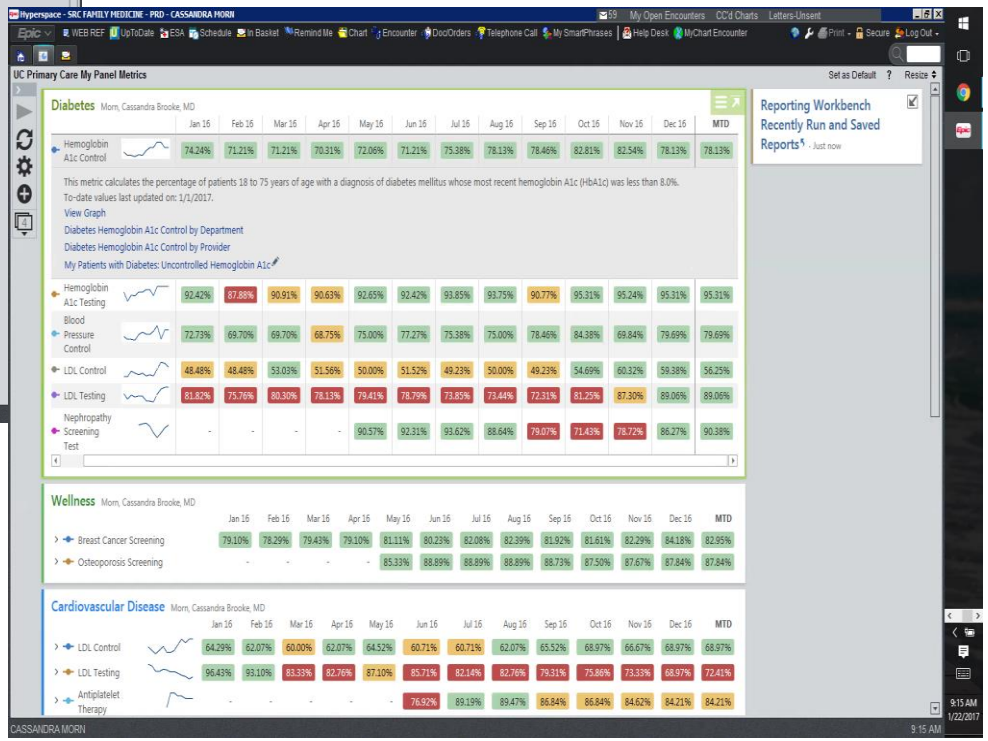
			Attainment		Improvement	October 2015	24 October 2016				
Measure	Measure Abbrv	Clinic	IHA 2015 75th Percentile	IHA 2015 95th Percentile	UCSD 2015 Final Rate (%)	Last Year at This Time (%)	Rate (%)	Num	Denom	Score	Add To Num For Max Score
Blood Pressure: In Control (Non-Diabetic w/ HTN): Ages 18-85	CBPH_1885	Scripps Ranch	66.64	83.81	64.07	No Data	73.86	65	88	5	8
Patients on Persistent Medications: Annual Monitoring Overall	MPMOV	Scripps Ranch	86.19	90.54	79.25	No Data	73.17	120	164	0	28
Diabetes: Blood Pressure Control (<140/90 mm Hg)**	CBPD4	Scripps Ranch	70.94	84.09	68.06	68.10	66.13	41	62	0	11
Diabetes: HbA1c Control < 8.0%	HBAC8	Scripps Ranch	65.42	71.18	69.84	66.80	74.19	46	62	10	0
Diabetes: HbA1c Poor Control > 9.0%***	HBACON	Scripps Ranch	22.91	15.87	10.12	No Data	4.84	3	62	10	0
Diabetes: One HbA1c Test	HBASCR1X	Scripps Ranch	Info Only	Info Only	Info Only	Info Only	85.48	53	62	Info Only	Info Only
Diabetes: Two HbA1c Tests	HBASCR2X	Scripps Ranch	67.24	83.37	63.49	49.00	53.23	33	62	0	19
Diabetes: Medical Attention for Nephropathy	NEPHSCR	Scripps Ranch	93.31	95.16	96.43	88.40	93.55	58	62	2	1
Diabetes: Optimal Care - Combination	ODCCOMBO	Scripps Ranch	34.61	43.85	49.21	No Data	37.10	23	62	3	4
Low Back Pain: Use of Imaging Studies†	LBP	Scripps Ranch	13.54	10.09	17.78	No Data	4.55	1	22	10	0
Children With Pharyngitis: Appropriate Testing	CWP	Scripps Ranch	92.58	96.27	SD	No Data	No Data	0	0	0	0
Upper Respiratory Infection: Appropriate Treatment for Children	URI	Scripps Ranch	98.24	99.3	96.20	No Data	No Data	0	0	0	0
Immunizations for Children: Combination 10	CISCOMBO10	Scripps Ranch	58.96	67.92	50.00	No Data	28.57	2	7	0	3
Immunizations for Adolescents: HPV (Female)	HPV	Scripps Ranch	34.09	41.85	28.57	25.50	44.44	4	9	10	0
Immunizations for Adolescents: HPV (Male)	HPVM	Scripps Ranch	29.83	39.56	22.22	8.50	33.33	1	3	6	1
Immunizations for Adolescents: Tdap	IMATDAP	Scripps Ranch	90.12	94.22	88.07	83.10	91.67	11	12	6	1
Immunizations for Adolescents: Combo2 (Meni & Tdap & HPV)*	IMACOMBO2	Scripps Ranch	NEW	NEW	NEW	NEW	33.33	4	12	NEW	0
Colorectal Cancer Screening: Ages 50-75	COL	Scripps Ranch	74.56	80.69	79.15	75.40	81.61	355	435	10	0
Breast Cancer Screening: Ages 50-74	BCS	Scripps Ranch	85.14	89.36	86.50	83.10	87.18	204	234	5	5
Chlamydia Screening: Ages 16-24	CHLAMSCR	Scripps Ranch	66.8	74.59	77.66	84.20	90.00	54	60	10	0
Cervical Cancer Screening	CCS	Scripps Ranch	82.51	91.19	80.77	No Data	83.36	471	565	2	42
Cervical Cancer Overscreening***	CCO	Scripps Ranch	15.23	6.98	6.99	No Data	11.19	60	536	5	-23

Acquired Points	94
Total Possible Points	190
Scripps Ranch Grade	49.5%
Tier 1 Incentive (≥39%)	-
Tier 2 Incentive (≥43%)	-
Tier 3 Incentive (≥47%)	-

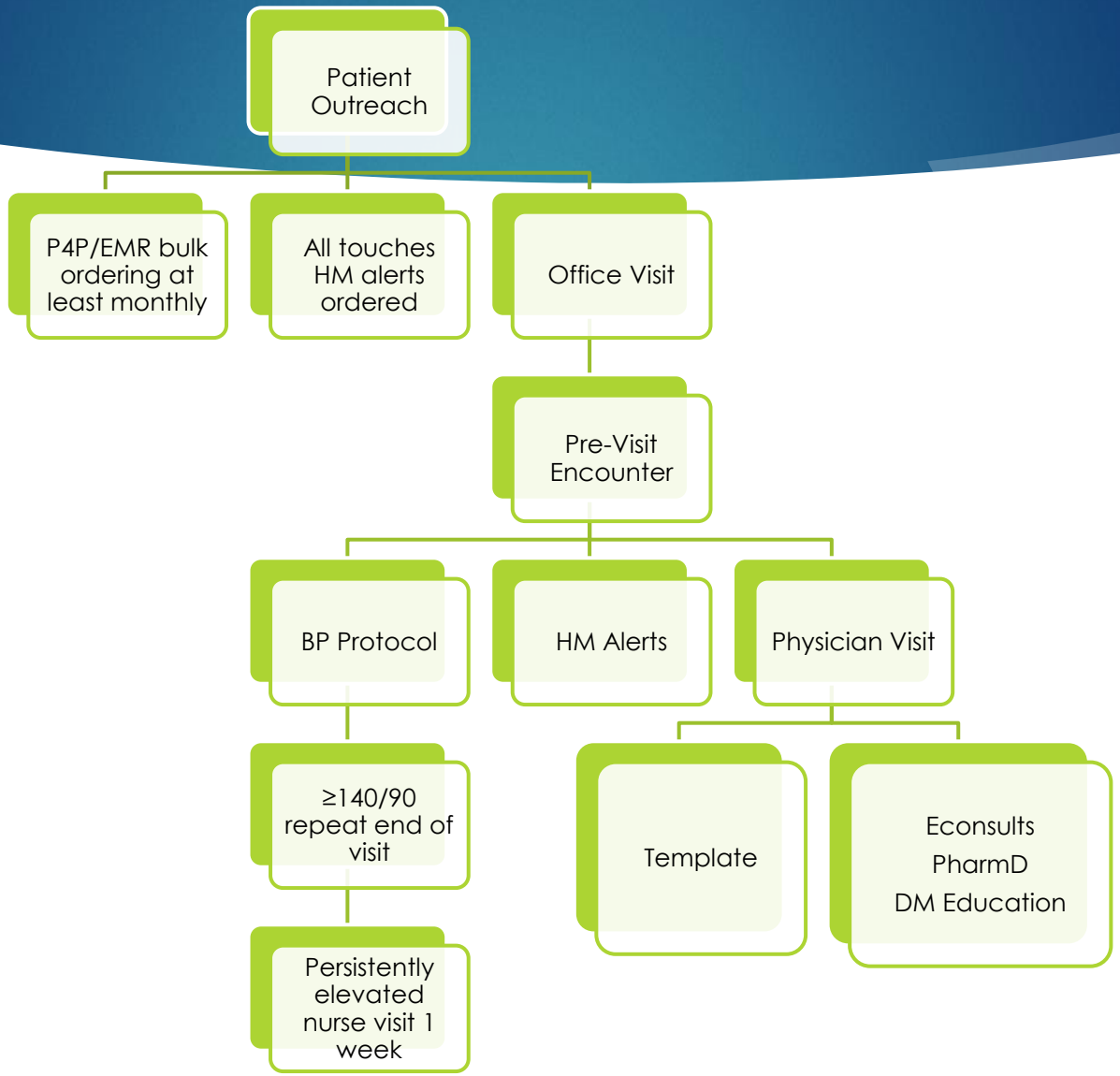
UC San Diego Health

Study: EMR Reports





Summary of Work Flow:



Act

- Feedback at clinic level
- Feedback to teams (MA/LVN/Physician)
- Incentives
- Assess Barriers
- Share Best Practices

Lessons Learned

Barriers

- Engaging medical team
- Ownership of population health
- Discrepancies across primary care clinics
- Time

Solutions

- Educate, incentives, ownership
- Team leaders that own patient outreach
- Standardize protocol and share best practices
- Implementation saves time

Resources

- UCSD CIN Protocol for Diabetes Management (word document) https://safetynetinstitute.org/wp-content/uploads/2016/05/1.2-cin-dm-protocol.docx
- PA Nutting et al. Journey to the Patient-Centered Medical Home: A Qualitative Analysis of the Experiences of Practices in the National Demonstration Project *Ann Fam Med 2010 8:S45-S56; doi:10.1370/afm.1075*
- *T Markova et al. Implementing Teams in a Patient-Centered Medical Home Residency Practice: Lessons Learned.* *J Am Board Fam Med 2012;25:224 –231*
- WK Bleser et al. Strategies for Achieving Whole-Practice Engagement and Buy-in to the Patient-Centered Medical Home *Ann Fam Med January/February 2014 12:37-45; doi:10.1370/afm.1564*

QUESTIONS?

Resources on SNI Link

- Posted on [Project 1.2 page]

Diabetes

- Information for Patients and Health Care Providers (American Diabetes Association)
- Standards of Medical Care in Diabetes—2017 (American Diabetes Association)
- Group Education Model (Healthy Interactions)
- Preoperative Management Policy (Ventura County)
- Protocol for Diabetes Management (UCSD CIN)
- Journey to the Patient-Centered Medical Home: A Qualitative Analysis of the Experiences of Practices in the National Demonstration Project (PA Nutting et al.; *Ann Fam Med 2010 8:S45-S56; doi:10.1370/afm.1075*)
- Implementing Teams in a Patient-Centered Medical Home Residency Practice: Lessons Learned. *(T Markova et al.; J Am Board Fam Med 2012;25:224 –231)*
- Strategies for Achieving Whole-Practice Engagement and Buy-in to the Patient-Centered Medical Home (WK Bleser et al. *Ann Fam Med January/February 2014 12:37-45; doi:10.1370/afm.1564*)

Project Leads on SNI Link

1.2 Contact list posted on PRIME Member Information

Alameda	Los Angeles	San Joaquin	UC Irvine
Physician Lead: Mark Maus mamaus@alamedahealthsystem.org Ops Lead: Holly Garcia hgarcia@alamedahealthsystem.org	Tyler Seto	Farhan Fadoo, M.D. ffadoo@sjgh.org	Erwin Altamira ealtamir@uci.edu Ivan Coziahr icoziahr@uci.edu Molly Nunez mollyn@uci.edu
Arrowhead	**Natividad**	San Mateo	**UCLA**
Contact PRIME Manager for questions: Staci McClane McClaneS@armc.sbcounty.gov	Contact PRIME Manager for questions: Anthony Leal LealAJ@natividad.com	Contact PRIME Manager for questions: Kristin Gurley kgurley@smcgov.org	Naveen Raja, Joyce Komori, Sam Skootsky
Contra Costa	**Riverside**	**Santa Clara**	**UC San Diego**
Rohan Radhakrishna Rohan.Radhakrishna@hsd.cccounty.us	Project: David Vargas davargas@rivcocha.org Clinical: Shunling Tsang, MD s.tsang@RUHealth.org	Monica Cramer Monica.Cramer@hhs.sccgov.org	Tyson Ikeda tikeda@ucsd.edu Marlene Millen mmillen@ucsd.edu
Kern	**San Francisco**	**UC Davis**	UCSF
Marie Ruffin (Lead): Marie.Ruffin@kernmedical.com Alicia Gaeta (Co-Lead): Alicia.Gaeta@kernmedical.com Gabriel Barajas (Co-Lead): Gabriel.Barajas@kernmedical.com	Reena Gupta, MD Reena.gupta@ucsf.edu	Lead: Tom Balsbaugh, MD tbalsbaugh@ucdavis.edu Manager: Vai Sagues, MBA vasagues@ucdavis.edu	Contact PRIME Manager for questions: Sara Coleman Sara.Coleman@ucsf.edu
			Ventura
			Theresa.Cho@Ventura.org Michelle.Laba@Ventura.org Admin Champions Renee.Higgins@Ventura.org Brighton.Ncube@Ventura.org June.Chung@Ventura.org

CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

PRIME Project Implementation Webinars

- Controlling Blood Pressure (Metric 1.2.5) – Thursday, February 23, 2017 12-1pm (Register Here)
- Colorectal Cancer Screening: Operational Practices and Resources (Metric 1.2.3) – Wednesday, March 1, 12:00-1:00pm (Register Here)

Information on all these webinars, including presentations and recording links, will be posted on SNI link here.

CLOSING

Take 2-3 minutes to let us know how we did in the post-event pop-up!

Thank you for joining us, and to our speaker!