| Project 1.1: Integration of Physical and Behavioral Health | |
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| **DPH strategies** | **Example Activities** |
| **Team based care** | **Multidisciplinary teams are providing comprehensive treatment to patients with chronic diseases and/or behavioral health needs.**<br><br>• **RUHS** is expanding its triad teams (clinical therapist, RN care manager and care coordinator) to a quad team, which will include a community health worker.<br>• **AHS** is developing a multidisciplinary chronic care team at all primary care sites to care for patients with diabetes.<br>• **UCI's** behavioral health team is available to provide brief treatment for patients with a positive PHQ9 score. |
| **Care coordination** | **Systems continue to co-locate primary care and behavioral health providers, as well as invest in the creation of collaborative care models.**<br><br>• **UCSD's** behavioral health clinicians are embedded in all primary care clinic sites and efforts are being made to embed BH services in newly opened clinics.<br>• **UCSF** launched the collaborative care model for depression treatment in the system's largest internal medicine practice.<br>• **UCD** has applied for an Archstone grant to pilot the implementation of the nationally recognized Collaborative Care Model.<br>• **KMC** is proactively connecting patients with high PHQ-9 scores to their co-located behavioral health team via an automatic alert structure, allowing for same day interventions.<br>• **NMC's** integrated model consists of LCSWs, warm handoffs, PA's and BH providers and an integrated BH coordinator who connects patients to community-based programs and ensures the timely transfer of patients to the appropriate level of care. |
| **Implementation and spread of screening tools** | **Behavioral health screening tools are being implemented and scaled across systems.**<br><br>• **AHS, SFHN and UCSD** have implemented behavioral health screenings for primary care patients across their networks.<br>• **SCVMC** is in the process of implementing a consolidated screening tool for depression, substance use and interpersonal violence across the majority of their clinics.<br>• **KMC** administers screenings through a technology platform which allows for instant notifications to the care team for any flags identified and more accurate tracking and follow-up. |
| **Investment in IT** | **Systems continue to invest in population health management tools, registries and health maintenance tools to allow for easier identification of patients and care coordination.**<br><br>• **LACDHS** launched a population health platform that allows for the identification and outreach to patients needing intervention.<br>• **UCI** continues its development of PHQ2 and 9 of metric dashboards for ongoing performance and improvement tracking. Additional registries are being developed to help manage patients by disease type.<br>• **UCSF** has developed a depression registry that serves as the patient identification tool for depression collaborative care teams. |
| **Staff recruitment and hiring** | **Behaviorists, psychiatrists and social workers are being added to primary care clinics in order to improve physical and behavioral health integration. Additional staff were also hired in response to the added patient demand as a result of active screening.**<br><br>• **AHS** and **CCRMC** are recruiting additional behavioral health clinicians to meet the added patient demand identified with active screening and improve access to care.<br>• **UCD** hired a new LCSW to provide case consultations and short-term behavioral health interventions in primary care.<br>• **SJGH** hired a psychiatrist in January 2018 to lead the integrated behavioral health, develop a collaborative care model and offer provider consults. |

| DPH strategies | Project. 1.1 Example Activities |
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| **Training and education** | **Providers are being trained on approaches to conduct behavioral health screenings and treatment.**<br><br>• **UCD** trained primary care physicians and staff members on depression screening using a comprehensive training toolkit and a train-the-trainer approach. The toolkit included: A presentation with embedded talking points; Depression Scale FAQs; Roleplaying common patient scenarios; Top 5 Training Tips; Weekly reports to track continual performance; PHQ-2/9 in different languages; and patient education resources.<br>• **UCSF** is engaging providers and staff on depression screening, treatment and collaborative care through multiple training sessions and Lunch and Learn opportunities. New depression team members were trained on motivational interviewing techniques, behavioral activation, treat-to-target methodologies, and weekly systematic case review methods.<br>• **VCMC** built on UCLA's Integrated Substance Abuse Program Motivational Training with classroom-based training and individualized programmatic support for SBIRT roll out. Plans are underway to spread these principles to promote better self-management for chronic disease management.<br>• **RUHS** is training all nursing staff, ambulatory care staff and providers and family practice residents on the use of SBIRT through online and in-person training.<br>• **CCRMC** has spread their Wellbeing Screen across all 11 health centers, and is focused on reinforcing best practices for screening through training and coaching initiatives, including targeted emails to providers and in-person observations of RN workflows. |
| **Strategic planning and process improvement** | **Systems have convened workgroups to improve patient care processes, implement best practices and address gaps through needs assessments.**<br><br>• **SFHN** has convened a group of leaders to assist with addressing gaps in screening and follow-up by actively engaging, training, and coaching primary care teams in substance use and tobacco screening, cessation interventions, depression screening, follow-up, and remission using a team-based care model.<br>• **UCI** has operationalized two steering committees to develop best practices and improve workflows.<br>• **UCSD** has engaged an active workgroup that meets regularly to design and implement changes around people, process and technology to improve our mental and behavioral health approach.<br>• **UCSF** has established multidisciplinary behavioral health integration workgroups with representation from primary care, psychiatry, nursing, social work, population health, and IT teams.<br>• **NMC** conducted an infrastructure capabilities and gap assessment, utilizing the tool previously used for a baseline assessment, to track organizational progress with implementing the PRIME Core Components. |
| **Workflow standardization and optimization** | **Standardized referrals and treatment tools are being put in place to enhance SBIRT and depression screening and standardize provider approaches.**<br><br>• **CCRMC** has begun to streamline behavioral health referrals into one referral for more efficient clinical workflow.<br>• **KMC** undertook a cross-disciplinary process to standardize the primary care template in the EHR, allowing for more detailed data collection. Staff and providers have been trained to examine the data collected and make the appropriate decisions based on information collected.<br>• **SJGH** has developed a workflow for providing age appropriate screening for drug and alcohol and substance abuse via a patient questionnaire to determine an intervention plan and further referral to treatment as needed.<br>• **UCSF** has developed standardized treatment options for patients who screen positive for depression in the EMR, which include automatic alerts with embedded recommendations for stepped care treatment protocols and medication order sets/SSRI titration.<br>• **UCLA** Is piloting a fully automated cloud-based data capture and clinical guidance tool within their integrated behavioral health care practice to guide treatment decision making, provide patient support tools, and monitor treatment to target. |

| DPH strategies | Project 1.1 Example Activities |
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| **Implementation of non-traditional services** | • **UCD** telepsychiatry services has demonstrated good outcomes for depressive and anxiety disorders and allowed for improved access to timely psychiatric evaluations. The Department of Psychiatry is planning to expand telepsychiatry services, by providing medication management and psychotherapy. |
| **Patient engagement** | • **KMC** teams provide phone outreach to individuals to schedule appointments. For example, there is a dedicated medical assistant to provide phone outreach to diabetic patients and assist with scheduling lab checks. |

| Project 1.2: Ambulatory Care Redesign | |
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| **DPH strategies** | **Example Activities** |
| **Implementation of non-traditional services** | **Non-traditional services, such as telephone visits, group visits and health coaches are being implemented to better manage complex, chronic conditions.**<br><br>• **RUHS** has implemented telephone visits to discuss medication management, provide motivational interviewing, and support lifestyle modifications for patients poorly controlled diabetes. Telephone visits have demonstrated an **improvement in A1c control and increase in A1c testing.** The increase in A1c testing also led the clinical algorithm committee to develop additional resources, such as diabetes pocket cards, for clinics to better manage their increased caseloads.<br>• **SCVMC** has successfully implemented group medical visits for controlling blood pressure, in collaboration with complex care nursing team and primary care behavioral health staff.<br>• **SFHN** implemented health coaching of patient self-management support for home BP cuff monitoring, physical activity and lifestyle modification. |
| **REAL/SOGI data collection** | **Several systems have begun REAL/SOGI data collection and are testing out new workflows to capture this data. Many more are developing materials and training staff to engage patients to collect this data.**<br><br>• **UCLA** is collecting REAL/SOGI data through the patient portal. They will also pilot tablet check-in with SO/GI questionnaires for new patients and those without MyChart access in their Gender Health Clinic. This Fall, there is a plan to launch a primary care tool for transgender patients which will include best practice advisories for transgender cancer screening.<br>• **UCSD** has implemented standardized workflows for the demographic documentation of race, ethnicity, sexual orientation and gender identity.<br>• **SCVMC** has trained nine clinics as well as Language Services and Valley Connection staff were trained on LGBTQ terminology, SO/GI work flow, health disparities, and communication practice sessions. SO/GI data collection for patients in 3 clinics in early 2018 and REAL data collection has become standard practice throughout the organization with a **71% patient response rate**.<br>• **KMC** has begun educating staff and providing guidance for collecting race and ethnicity data. |
| **Workflow standardization and optimization** | **Clinical algorithms, standardized protocols and pre-visit planning processes are being implemented for disease management.**<br><br>• **SCVMC** has integrated its screening tools into one annual screening and built reporting capabilities that would be compatible across PRIME, GPP and WPC.<br>• **RUHS** has developed chase lists for proactive management of patients with uncontrolled diabetes seen in the last 2 weeks, and clinics are in the process of piloting workflows to utilize the reports.<br>• **SJGH's** multidisciplinary team has introduced pre-visit planning to help patients understand and maneuver through clinics.<br>• **UCD** implemented pre-visit planning for patients with diabetes and those prescribed long-term opioids at 12 of its primary care sites.<br>• **CCRMC, LACDHS, SFHN, KMC, VCMC and UCSD** have implemented new protocols and standard work around blood pressure, including standardized BP measurement and repeat measurement protocols.<br>• **VCMC** implemented automatic alerts for elevated blood pressure values to remind primary care providers to take evidence-based actions. **SFHN** has implemented a standardized hypertension medication intensification algorithm.<br>• **UCSD** has adopted the use of protocols diabetes management, referral communication, and tobacco cessation to support evidence-based care. **RUHS** has developed diabetes medication titration algorithm and an algorithm to recheck and alert providers for elevated blood pressures at 2 clinic sites. |

| DPH strategies | Project 1.2 Example Activities |
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| **System integration** | **LACHDS'** recent integration of DHS with the Department of Public Health (DPH) and Department of Mental Health (DMH) will add resources, which we can be leveraged to provide treatment for those identified via SBIRT screening as needing intervention. |
| **Disparity reduction** | **Systems are conducting outreach to reduce disparities in their target populations. Staff are undergoing training and developing stakeholder relationships to create culturally relevant interventions. Dashboards are being developed to monitor and enhance operational performance in clinics.**<br><br>• **LACDHS** saw a **5% improvement in colorectal cancer screening** among **African American** patients from DY12 to DY13. They continue to seek improvements in their screening rates by introducing FIT test mailers, which include instructions and pre-paid return envelopes.<br>• **SFHN** is focused on closing the disparity gap in **blood pressure control for Black/African American patients** through the use of: HTN registries, dashboards, nurse led HTN visits, standardized treatment protocols, health coaching and panel management outreach. Efforts have also focused on building stakeholder relationships and partnerships with patient advisors, public health and community organizations, which has led to the implementation of nurse chronic care visits and partnerships with Food Pharmacies.<br>• **SJGH** is planning to develop and implement culturally **appropriate health promotion, outreach and education initiative to reduce the disparity in blood pressure control among African American patients**. This effort will be complemented by community-based activities conducted to engage patients' families and community leaders. In addition, the population health coach is adding a dedicated health coach.<br>• **SMMC's** disparity reduction efforts for **reducing blood pressure among African American patients** include data mining to identify at risk patients and dissemination of disparities data and outreach to specific patients in the affected population. Through these efforts, SMMC has **reduced its disparities gap by 5 percentage points.**<br>• **UCLA** held a CME event to educate primary providers on treatment approaches that could potentially help in addressing the **blood pressure disparity in the African American** patient population.<br>• **UCSF** disparity reduction pilot for reducing **blood pressure in African American** patients included a letter to the patient signed by their primary care provider along with educational resources and a voucher for a blood pressure monitoring cuff and a pill box to help with medication adherence, and an in-person education session with a nurse on how to use the blood pressure cuff.<br>• **KMC** plans to implement a Social Determinants of Health electronic screening program to help us better identify disparities among our patient population.<br>• **NMC** uses business object reports in its EMR to improve quality and close gaps in care. Clinic providers use dashboard reports to monitor metric performance. |
| **Redefining roles & responsibilities** | **Workflows are being redefined to allow RNs to work to the top of their license and provide more comprehensive treatment for chronic disease management.**<br><br>• **SFHN** primary care has engaged nurses in RN Chronic Care Visits for hypertension, pharmacists for ischemic vascular disease panel management, and behavioral assistants and medical assistants for tobacco cessation counseling.<br>• **SMMC** is developing standardized guidelines for RN-only hypertension and diabetes visits. |

| DPH strategies | Project 1.2 Example Activities |
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| **Improving the patient experience** | **Systems are changing patient-provider communication workflows, designing culturally appropriate materials, training staff and engaging patient advisors to improve the overall care experience.**<br><br>• **ARMC** is working to improve the patient experience through the following initiatives: hourly patient rounding, leader rounding on patients, improved bedside reporting and increased communication in the waiting room.<br>• **SFHN**'s Primary Care designed clinical and communication tools that are culturally appropriate and informed by patient advisors.<br>• **KMC** implemented customer service training for all staff and established a new role of Director of Patient Experience, with the ultimate goal of establishing standing patient advisory councils. |
| **Use of QI tools** | **Systems have employed QI tools, such as Lean management methodologies to improve metric performance.**<br><br>• **SFHN** Primary Care is promoting Lean A3 problem solving with standardized training for clinical QI leaders and use of A3s to develop data-driven strategies to improve performance across its network.<br>• **RUHS** has focused on spreading the use of LEAN methodologies throughout the organization to help improve efficiencies, decrease waiting room times, improve cycle times, and provide more consistent communication with patients, providers, and staff.<br>• **UCSF** has adopted a Lean culture transformation and has instituted true north boards in every clinic and leader rounding: access, quality of care, patient experience and staff engagement are all addressed at the clinic level and goals are tailored to the clinics baseline performance. |
| **Improving access to care** | **Systems are improving access to care through: earlier discharge appointments, improved scheduling and increased staff and provider counts.**<br><br>• In order to minimize loss to follow-up for patients identified with high blood pressure, **LACDHS** has added close-timeframe nurse visits (5-7 days) and they plan to implement pharmacist-driven blood pressure clinics in the future.<br>• **SJGH** expanded provider and population health staff and opened new primary care clinics.<br>• **UCSD** has deployed of primary care web-based direct scheduling to improve access. |
| **Patient engagement** | **Panel management strategies include both outreach and inreach through the use of registries and automated software to identify and provide the appropriate treatment and screenings to patients.**<br><br>• **AHS** primary care teams are closing care gaps by conducting inreach for patients with hypertension and diabetes.<br>• **ARMC** will be rolling out its patient portal in clinics and assisting patients with sign up. **RUHS** is educating providers to market the patient portal so that patients can access their medical records, schedule appointments, and communicate with their provider.<br>• **CCRMC** has enhanced their management of patients with diabetes by automatically sending an email or letter to patients with missing lab work and conducting additional outreach for those who remain out of compliance.<br>• **SFHN** developed population health registries across multiple metrics, which it is using to identify patients for outreach to improve care around hypertension, tobacco use, IVD, and colorectal cancer screening. SFHN is also conducting panel management outreach for patients with uncontrolled hypertension using standardized scripts and outreach tracking.<br>• **SMMC** is providing focused data to care teams to leverage opportunities for inreach and provide cancer screening services during upcoming face to face visits with patients in need of screening completion.<br>• **UCLA** has invested in technology to call our patients who are out of date with their health maintenance.<br>• **UCSF** refined panel management workflows across primary care with the use of automated software and workflow management technology – allowing staff **to engage 3.86 times as many patients.** They also built preventive cancer screening registries into the EHR, and linked these registries with its automated telephonic outreach protocols.<br>• **KMC** conducts phone outreach for patient education on medication management. |

| Project 1.3: Ambulatory Care Redesign: Specialty Care | |
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| **DPH strategies** | **Example Activities** |
| **Development & spread of eConsult/eReferral services** | **eConsult/eReferral is being implemented across a variety of specialty services and systems are developing templates and protocols to improve the quality of specialty care referrals.**<br><br>• **RUHS** began its Multi-county eConsult Initiative pilot in March 2018 and is anticipating full spread across all of primary care clinics before the end of calendar year 2018.<br>• **AHS** is planning to a new, centralized referral platform for both internal and external reviewers in DY14. **SJGH** is planning to roll out their eConsult system in the next DY.<br>• **ARMC, CCRMC, LACDHS, SCVMC, UCD, UCSD, SMMC, UCLA, UCSF and VCMC** have all implemented eConsult across a variety of specialty clinics, and many systems are in the process of expanding to additional providers.<br>• **UCSD** developed and built Smart Referral template into the EMR in order to improve the quality and content of referrals. **SMMC** implemented over 200 clinical guidelines as part of its eConsult platform.<br>• **UCSF** engaged various health plans to develop reimbursement strategies for specialty e-consults as a way to ensure long term sustainability of these innovative care models. **VCMC** is also looking to engage future partners in its eConsult effort, including other hospitals, clinics and their locally-managed Medi-Cal health plan.<br>• **KMC** is exploring e-consult solutions to enhance the efficiency and effectiveness of consults.<br>• **NMC's** specialty practice work group transformed its manual referral system to an electronic process and is now piloting a process to request non-face specialty encounters. |
| **Implementation of other non-traditional services** | **Video visits and other telehealth services are being used across agencies and providers.**<br><br>• **RUHS** is actively using telehealth in their detention clinic, and are awaiting expansion to the county jail system. RUHS is also planning to go live with clinic to clinic telemedicine for Geriatrics, which will soon be followed by a system wide telemedicine initiative.<br>• **UCD** has expanded The MyChart Video Visit program, with 10 providers currently active and 14 pending implementation. |
| **Patient engagement** | **Post-discharge phone calls and outreach via the patient portal has helped to improve communication with patients.**<br><br>• In an effort to reduce readmissions, **KMC** has started to implement post-discharge phone calls to check patient status and to ensure medication compliance.<br>• **SCVMC's** My Health Online patient outreach portal has improved communication with patients requesting access to specialty providers. |
| **Leveraging data** | **Systems are utilizing dashboards, registries and integrating disparate IT systems to allow systems to better utilize data.**<br><br>• **LACHDS** has brought all the Public Health providers onto their unified medical record.<br>• **SFHN** shares stratified eConsult response time data and best practices for improving those times with each specialty clinic and individual providers.<br>• **UCSF** has established a comprehensive access Qlikview dashboard, which displays real time access data by clinic. |

| DPH strategies | Project 1.3 Example Activities |
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| **Workflow standardization and optimization** | **Project activities include the development of templates and protocols to improve the quality of specialty care, pre-visit planning processes and eConsult services.**<br><br>• **SCMVC** improved the timeliness of their referrals by standardizing workflows and increasing the number of staff with access to data reporting tools**.**<br>• **SFHN's** has created a substance use disorder (SUD) readmissions reduction strategy that is focused on creating medication treatment protocols, increase screening and diagnosis of SUD, and implementing an addiction medicine consult service.<br>• **NMC** is working with a consulting company to implement NCQA Patient Centered Specialty Practice processes and workflows, including new pre-visit planning processes. |
| **Expansion of flu immunizations into specialty care** | **Systems are developing protocols, training staff and conducting outreach to expand flu vaccines into specialty care.**<br><br>• **SFHN** has directed efforts at offering influenza vaccinations in the specialty care clinics by developing and implementing standard work for providing vaccinations as well as designing training protocols for staff.<br>• **UCSF** is working to expand flu immunizations by: allowing medical assistants to administer vaccinations, dedicating vaccination clinics at every primary care practice and implementing an automated phone call outreach program to collect information on flu shots received outside the system.<br>• **UCD** began making automated patient calls to engage patients and collect patient-generated flu data. They also developed a focused training tool, disseminated to all clinics, for documenting external flu vaccines in EHR. |
| **Improving access to care** | **Systems are improving access to care through: improved scheduling, development of a centralized call center and through the implementation of non-traditional services.**<br><br>• **SJGH** is in the process of implementing a centralized scheduling unit, which will be responsible for acknowledging and scheduling referrals to specialty care.<br>• **UCSF** has expanded access to care using a variety of strategies, including: expanding physical space and staff, improving room turn over time and scheduling follow up appointments by phone or via tele-health. |
| **Care coordination** | **Multi-disciplinary teams and care navigators are being tasked with improving readmission rates by co-managing patients both in clinics and after discharge.**<br><br>• **RUHS** will be embedding a Psychiatric Clinical Pharmacology Clinic in the rheumatology and infectious disease clinics to help co-manage patients, with a focus on their behavioral health co-morbid conditions.<br>• **UCI** has begun co-locating specialty services in its call center.<br>• **SCVMC's** specialty team Complex Care Nursing team and primary care Complex Care Nursing team operate in concert by following patients after discharge based on the complexity of the patients.<br>• **SFHN** implemented a **Transitional Care Nursing program** which identifies patients that are at high risk for readmissions and provides care coordination and self-management support prior to and following hospital discharge. They also implemented a **Multidisciplinary Complex Care Management team** focused on addressing social needs among patients presenting to the ED, to effectively link patients to community-based medical and social support resources and preventing readmissions. |

| Project 2.1: Improvements in Perinatal Care | |
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| **DPH strategies** | **Example Activities** |
| **Improving access to care** | **Policies are being developed to identify and engage patients to provide better access to timely pre and postnatal care.**<br><br>• **CCRMC** added a drop-down menu in our electronic health record to document WIC prenatal class completion for targeted outreach.<br>• **RUHS** is developing a policy for same day OB appointments for all women with a positive pregnancy test and expanding outreach and incentivizing post-partum visits at time of discharge.<br>• **SFHN** built a postpartum registry to identify and provide outreach to patients who have not attended a postpartum appointment. An electronic notification system has also been implemented to improve scheduling of postpartum appointments and new workflows have been developed for panel management.<br>• **SJGH** is working with the local health plans to ensure patients receive incentives attending prenatal and postpartum visits. |
| **Breastfeeding promotion** | **Systems are promoting breastfeeding through cross-sector collaborations, the hiring of new staff members, provider and staff education, policy changes and by making donor milk more readily available.**<br><br>• **ARMC** began treating formula as a medication and started a donor breast milk program, both of which has led to a considerable overall increase in lactation rates. ARMC also hired a lactation consultant to drive improvement in both inpatient and outpatient breastfeeding education for patients. She has also expanded her training to include all L&D nursing staff.<br>• **CCRMC** has trained **97% of nurses and over 60% of physicians in breastfeeding practices**. Other activities include: a video for providers on breastfeeding, live breastfeeding trainings, updates to the infant feeding policy and redesign of education packets to meet breastfeeding requirements.<br>• **SFHN** has been providing nursing and provider breast feeding education, conducting chart audits with direct provider feedback, and promoting practices that are known to prevent formula supplementation. SFHN has implemented an assessment tool for RNs to identify dyads at risk of formula supplementation, and is working towards having donor breast milk available for patients with maternal contraindications to breastfeeding.<br>• **SJGH** changed policies to avoid formula supplementation and significantly enhanced its education to patients, staff in the family maternity unit, staff in clinics, and physicians to improve rates.<br>• **UCSD** is working on improving its prenatal breastfeeding education, developing a transitional care pathway for fragile infants to improve early breastfeeding access, developing of an app for breastfeeding information, and introducing donor breastmilk as supplement for term infants and instruction of mothers in hand expression.<br>• **UCSF** has a strong team of board-certified Lactation Consultants who help mothers learn breastfeeding techniques throughout their hospital stay. They have also implemented new workflows and resources to make donor breastmilk more accessible to patients, including creating additional freezer storage space for donor breastmilk within the well-baby nursery and by modifying the content and the timing of the donor breastmilk consent process.<br>• **VCMC** is slated to have at least one dedicated International Board-Certified Lactation Consultant in the OB unit.<br>• **RUHS,** in collaboration with the Riverside County WIC breastfeeding liaisons, provides a standardized breastfeeding and baby behavior education program is provided to all clinics. |
| **Hemorrhage bundle implementation** | • **NMC, SFHN, RUHS, UCSD, UCI, UCSF, VCMC** and **UCD** have fully implemented all OB hemorrhage bundle elements in DY13. |

| DPH strategies | Project 2.1 Example Activities |
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| **Training and education** | **Staff are being trained on patient safety, post-partum care and the proper identification and treatment of preeclampsia.**<br><br>• **AHS** routinely reinforce their emergency preparedness and management and collaborative care models, in order to maintain low primary cesarean rates and excellence in managing maternal hemorrhage.<br>• **SJGH's** Family Maternity Center implemented the POST-BIRTH Warning Signs education program aimed at increasing the capacity of nurses to provide pre-discharge education to mothers on the importance of postpartum care.<br>• **UCSF** and **VCMC** both conducted Team STEPPS training.<br>• **UCSF** also identified a training partner who will offer Baby Friendly Hospital education for over 200 nurses and 45 providers in the upcoming demonstration year.<br>• **VCMC** provided training to nursing staff and providers about the appropriate and prompt treatment of hypertension and the Preeclampsia Policy is under revision to align the treatment algorithm with current practice. |
| **Baby Friendly designation** | ***Achieved:***<br>AHS<br>ARMC<br>RUHS<br>UCSD (Hilcrest, Jacobs Medical Center)<br>UCI<br>UCLA (RRMC achieved in DY12, SMH achieved in DY13)<br>NMC<br>ZSFG<br>VCMC<br>SJGH<br><br>***In progress:***<br>**Development phase:** UCSF, UCD, KMC (completed)<br>**Dissemination) phase:** CCRMC<br>**Designation phase:** SCVMC |

| 2.2: Care Transitions: Integration of Post-Acute Care | |
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| **DPH strategies** | **Example Activities** |
| **Improving the patient experience** | **Systems are working to improve the patient experience through rounding, multidisciplinary patient experience workgroups, provider champions and improved communication through scripting and education materials.**<br><br>• **AHS** is using nursing rounds to improve patient satisfaction scores related to care transitions.<br>• **SCVMC** launched its Patient Experience Program, which included the training of 100 direct patient care providers as patient experience champions. The Patient Satisfaction Across Continuum of Care and Customer Experience Committees were established to develop an organizational culture conducive to providing excellent patient and family experience.<br>• **CCRMC** is working to improve the patient experience by adding roving snack carts, in-room televisions and headphones, and free wifi.<br>• **SJGH** initiated a patient experience workgroup that is focused on improving patient care and the patient experience in the hospital by providing information folders to patients prior to discharge to support care transition needs, restructuring care management to provide more front-line support to patients, improving quality of information provided to patients related to medicine and pain management, and conducting daily leadership rounding.<br>• **SMMC** developed scripting for nurses and physicians to make sure patient preferences are being obtained around discharge needs. |
| **Care Coordination** | **Systems are supporting care transitions through dedicated complex care management teams, post-discharge phone calls and care navigation.**<br><br>• In June 2018, **CCRMC** fully launched automated post-discharge phone calls to patients, and raised awareness of these calls by adding information in the discharge summary with screensavers and through nurse and provider outreach.<br>• **SCVMC** piloted pharmacist-driven med management in 3 clinics for patients on 9+ medications, and plans for expansion in all clinics.<br>• **UCSF** primary care patients with multiple conditions or high inpatient utilization are being managed by the Complex Care Support team. The Care Transitions Outreach Program calls patients within 72 hours of discharge to ensure a smooth transition home to address any concerns related to medications, symptoms, or follow-up care.<br>• **RUHS** implemented a Safe at Home Program", which identifies high-risk patients that require an in-person patient navigator visit prior to discharge that can assist with the transition of care and setting up post discharge appointments.<br>• **SMMC** piloted a discharge huddle where the provider, nurse and case manager meet with the patient and family at the bedside just prior to discharge to determine if the patient is able to recount everything learned during their hospital stay.<br>• **SCVMC's** Project RED and Transitional Care Model are being adopted to promote coordination of care, enhance patient and family experience, and decrease unplanned re-hospitalizations.<br>• **SFHN's** Patient Care Coordinators and Transitional Care Nursing works with patients to help them gain a better understanding of their diagnoses and develop a care plan following discharge. SFHN is improving 7-day post discharge follow up via panel management outreach and providing care coordination and self-management support to patients identified at high risk for readmission.<br>• **UCI** added three new health coaches to their existing two to provide navigation services and conduct follow-up calls to ensure patients have a PCP appointment within 7 days of discharge. |
| **Cross-sector collaboration** | **Systems are partnering with their health plans, long term care facilities, home health agencies and other community partners to improve the transition of care for patients.**<br><br>• **UCI** is partnering with size skilled nursing facilities, one long term acute care hospital and is in the process of evaluating four potential health home agencies to improve the care transition of patients.<br>• **UCSF** formed quality collaboratives with neighboring home health agencies and SNFs with the goal of ensuring efficient, needs-based and effective transitions between UCSF and community partners. This collaborative provides an avenue for communication and training on protocols for complex patients with CHF and COPD, ensuring reliable information transfer, improving verbal handoffs, and providing discharge contact information for open patient discussion. |

| DPH strategies | Project 2.2 Example Activities |
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| **Workflow standardization and optimization** | **Services and care documents are being standardized to improve communication and the discharge planning process.**<br><br>• **CCRMC** will be training nurses to identify patients 1-2 days prior to discharge to secure and schedule a PCP appointment.<br>• **AHS** created a standardized transition of care document, which is available in the EMR within 24 hours post discharge.<br>• **RUHS** added care transition information to patient room communication boards. Extensive training was given to staff and providers on care transitions, including detailed medication education and post discharge patient responsibilities. The team is also developing a discharge folder to facilitate organization of patient's hospital documents as well as a comprehensive discharge checklist.<br>• **SMMC** is developing a short discharge checklist to make sure patients have all the necessary discharge information.<br>• **UCSD** engaged a multidisciplinary group including pharmacists, pharmacy technicians, physicians and RNs to standardize the med rec process across all clinic locations.<br>• **VCMC** is creating new tools to assess risk of readmission, creating better discharge documents and making post-hospital phone calls to patient to ensure appropriate follow-up. |
| **Team based care** | **Workgroups and multi-disciplinary care teams are being utilized to improve communication and coordinate care for patients after discharge.**<br><br>• **SFHN** is improving and standardizing multidisciplinary rounds to emphasize coordination, communication and team-based care, by assessing and addressing patients' complex medical and social needs.<br>• **UCSF's** post-acute care collaborative is a venue for provider partners to come together quarterly to review care coordination successes, opportunities, and to set clear standards for supporting patients after discharge.<br>• **NMC's** care transitions workgroup focused on improving patient education related to readiness for discharge, creating a more customized approach and clarifying the RN role.<br>• **SMMC's** multi-disciplinary care transitions committee is working to align care with the PCMH. |
| **Leveraging data** | **Dashboards, reports, registries and risk assessment tools are being used to prevent unnecessary readmissions.**<br><br>• **SCVMC** uses EMR reports, BI Launchpad & Tableau dashboards to provide clinicians with electronic data monitoring tools.<br>• **UCSD** utilizes of risk scoring to identify target patients.<br>• **UCSF**'s readmissions dashboard is used to track readmission rates and discharge quality process metrics such as timely follow-up.<br>• **KMC** created a readmission risk stratification tool that is given to all patients in the inpatient setting. This allows for proactive outreach, post-discharge phone calls and coordination of care for all patients to ensure a smooth transition out of the inpatient setting and into the primary care setting.<br>• **NMC** developed a readmissions registry report to allow for improved efficiencies in annual readmission data analysis.<br>• **NMC** implemented the LACE tool to identify patients at risk for readmission, and 100% of patients with a score of > 10 receive a phone call with in 48 hours of discharge. |
| **Increasing access to care** | **Same day appointments, walk-in clinics, extended hours, earlier discharge appointments and call centers are all part of the strategy to improve timely access to care.**<br><br>• **LACDHS** is expanding outpatient access, providing earlier discharge appointments, creating a call center and improving the discharge planning process and assessment for discharge readiness.<br>• **UCI** is improving clinic access by adding physicians and new practice locations. Previous work included the addition of more same day appointment, walk-in clinics and extending clinic opening hours into the evening.<br>• All **UCSF** primary care practices are under the PCMH model to proactively engage patients on getting timely preventative and chronic care services in the ambulatory setting. Telehealth visits were piloted as an effective post-discharge follow-up approach at selected clinics. |

| Project 2.3: Complex Care Management for High Risk Medical Populations | |
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| **DPH strategies** | **Example Activities** |
| **Investment in IT** | **Systems are investing in risk scoring & predictive tools, Health Information Exchanges, registries, dashboards and health alerts to track and care for this patient population.**<br><br>• **SFHN** developed a validated PRIME Complex Care population list from which to recruit patients into Primary-Care based complex care management programs. **UCSF's** complex care registry is used regularly to identify and engage high risk patients.<br>• **RUHS** has developed EHR dashboard reports to enhance identification, prioritize high-risk patients at the point of care, as well as providing ADT tracking notification for patients' ED and admission utilization.<br>• **LACDHS** has invested in a population management oriented, enterprise-wide Patient Registry and Empanelment system that allows for the tracking of specific cohorts of chronically ill patients and provides opportunities to address concerns and gaps in their care.<br>• **SCVMC** has implemented readmission predictive tools, complexity and gap scores to identify high risk patients for care coordination and complex care management.<br>• **SFHN** has implemented a new Emergency Department Information Exchange that collects and collates clinical information from all inpatient and ED visits and sends real-time notifications to providers about high-risk patients.<br>• **SJGH** will be implementing the HealtheIntent population health management tool in DY14, which will offer robust care management functionality including tools to support stratification of patients to readily identify patients at high risk.<br>• **UCSD** is using registries to construct custom risk scores and identify the 5% of patients at highest risk. Efforts are being made to enhance the custom risk scoring performance over time through addition of social determinants and chronic disease registries. |
| **Care coordination** | **Nurse managers are being embedded into clinic sites to help coordinate care, provide education and help prevent avoidable readmissions.**<br><br>• **ARMC** has embedded a RN Care Manager into each of its 3 primary care clinics to provide education, coordinate care and provide discharge follow-up when indicated.<br>• **SCVMC** Clinic Complex Care Nurses make follow-up phone calls and provide medication education, linkages to services, provision of transportation to and from appointments, and/or referrals to other programs.<br>• **VCMC** has embedded two full-time RN care managers who work emergency department to help prevent avoidable readmissions and better compliance with the hospital risk assessment tool.<br>• **AHS** has developed and deployed a community health worker training program. |
| **Workflow standardization and optimization** | **Best practice and referral protocols are being developed for panel management and to provide higher quality care for patients with chronic conditions.**<br><br>• **RUHS** has developed best practice algorithms, including RN workflows and medication titration protocols for complex conditions.<br>• **AHS** developed a new referral process to allow primary care providers to review their panels for eligible patient and workflows to obtain & report regular data on team productivity, panel sizes, new patients enrolled. |
| **Increasing access to services** | • **SCVMC** piloted a Vivitrol program in DY12 is planning to increase the number of PCPs who provide medication assisted therapy. |
| **Collaboration** | • **KMC** has partnered with one of its managed care providers to create two Patient Centered Medical Homes to better meet the treatment needs of high-utilizing patients. |

| DPH strategies | Project 2.3 Example Activities |
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| **Coordination with other waiver areas** | • **CCRMC** leveraged its electronic health record system for shared documentation between the PRIME 2.3 team and WPC to improve care coordination. CCRMC's PRIME pilot program for high acuity patients, Care Connect, took on additional patients who did not fit WPC criteria and successfully placed in more appropriate long-term licensed care facilities. |
| **Team based care** | **Systems are embedding multi-disciplinary teams in clinics to manage behavioral and physical health and complex diseases.**<br><br>• **AHS** has standardized its care model and staffing, embedding a complex care management team at an additional primary care clinic.<br>• **UC**I's new ACO developed a clinical group of health coaches, coders, RNs, LCSWs, NPs and PharmDs to co-manage high risk patients.<br>• **RUHS** care management teams implement screening for behavioral health and substance abuse disorders, provide proactive patient outreach initiatives, and conduct care planning.<br>• **UCSF** holds a weekly interdisciplinary case conference where patient care plans are refined and team recommendations are shared with the PCP. |