Project 1.1: Integration of Physical and Behavioral Health	
DPH Strategies	**Example Activities**
Care Coordination	**Systems continue to co-locate primary care and behavioral health providers, as well as invest in the creation of collaborative care models. Additional staff are also being hired to accommodate the increase in services.** • **RUHS** is integrating psychiatry services into each FQHC and is in the process of onboarding several psychiatrists. They also added licensed clinical therapists to clinics for patients with mild to moderate BH and substance use issues. • **UCD** is expanding BH services in primary care to support patients with major depression. They also received a 3-year Care Partners grant to provide enhanced collaborative care for older adults with depression. • **UCSD** has increased their BH team in order to begin embedding BH services into newly opened clinics. • **UCSF** is expanding the number of staff and availability of its depression collaborative care teams based on its pilot success. • **ARMC** has SHAPE (Supporting Health and Personal Empowerment, formerly known as the Behavioral Health Integration Complex Care Initiative) teams located at 3 Primary Care Clinics who coordinate care with the empanelment teams and engage in warm hand-offs from the provider for continuity of care purposes. • **UCI** utilizes LCSW as part of their Collaborative Care model and has begun recruiting Case Managers in DY14.
Implementation and spread of screening tools	**Behavioral health screening tools are being implemented and scaled across systems.** • **RUHS** has built a Best Practice Advisories in the EHR for depression screening follow-up and depression remission workflow. • **SCVMC** is building new population health depression management tools for all primary care patients with a qualifying diagnosis and a PHQ9 score of >9. They are also working on expanding standardized BH screenings to OB and pediatrics. • **SFHN** is rolling out their Behavioral Health Vital Signs tool across all primary care clinics in the network, which includes depression screening and follow-up and alcohol and substance use questions. • In the first half of DY14, **SMMC** screened close to 4200 patients for depression (2,200 met PRIME criteria).
Workflow optimization and reinforcement of best practices	**Systems are reinforcing best practices by standardizing screening protocols, documentation, and staff/provider trainings.** • **CCRMC** is continuing to reinforce best practices for screening reliability and consistency across health centers with training, coaching, in-person consultations and emails. • **KMC** standardized a primary care template in their EHR. • **UCD** is piloting a new depression screening workflow and follow-up plan documentation tools in their EMR. All PCPs and staff have been trained on these workflows using a train the trainer approach and a comprehensive training toolkit. • **UCI** operationalized two steering committees focused on developing workflows and best practices to improve patient outcomes. • **UCLA** has developed standardized protocols and procedures for depression/SBIRT screening, which will be expanded this DY. • **VCMC** developed quick reference sheets to better assist staff and providers with understanding key areas of care, documentation, and coordination. • **SJGH** started flagging any patient deficient in any 1.1 measure (including behavioral health screenings, cancer screenings, advance directives and other chronic disease management indicators) in four clinics and will be expanding to the remaining clinics by the end of DY14.

Embedding behavioral health in primary care	• **SJGH** is planning to expand its behavioral health and primary care integration to all of its French Camp clinics during the second half of DY14 and add additional BH staff to its clinics.
DPH Strategies	**Example Activities**
Investment in IT platforms	**Systems continue to invest in population health management tools, registries and health maintenance tools to allow for easier identification of patients and care coordination.** • **LACDHS** launched a population health platform which allows for identification and outreach to patients needing intervention. • **UCI** is developing registries to help manage sub-groups of patients by disease types. • **UCLA** has launched a fully automated cloud-based data capture and clinical guidance tool within their integrated behavioral health care practice. This tool is being piloted and is expected to be rolled out to the greater primary care system later in 2019.
Chronic disease/pain management	**Systems are creating targeted approaches to intensively manage patients with chronic disease or substance use concerns. Approaches include standardizing existing workflows, providing intensive disease management and developing and training staff on best practices.** • **UCSD** has expanded resources to support patients with uncontrolled DM, including diabetes education, intensive diabetes visits with a pharmacist and the availability of electronic consults with an endocrinologist. A new program has also been implemented in collaboration with population health, endocrinology and primary care where patients with an HbA1c>9.0 will be offered an intensive management program with weekly motivational interviewing, diabetes education, glucose monitoring and access to endocrinology consultation. • **UCSF** convened a Systemwide Opioid Taskforce to assess system level gaps related to opioid dependence. Priorities include 1) understanding the scope of opioid use among UCSF patients and create actionable data; 2) standardize clinical toolkits to support best practice; 3) develop standard patient facing support tools; and 4) develop mandatory standard training for all providers who prescribe opioids. • **ARMC's** High Utilization Patient Care Outreach (HUPCO) Program RN Care Managers have developed tools to track and trend preventable acute care utilization and emergency room visits. • **SJGH's** pre-visit planning team created chart alerts, to notify the MA and provider team of gaps in care.

Project 1.2: Ambulatory Care Redesign	
DPH Strategies	**Example Activities**
Redefining roles & responsibilities	**Workflows are being redefined to allow MAs and other health care staff to work to the top of their license and ensure patients are receiving adequate preventative care.** • **AHS** primary care teams have developed standing orders for MAs to: order FIT tests and conduct outreach calls to patients. They have also empowered MAs to close care gaps during intake.
REAL/SOGI data collection	**Several systems have begun REAL/SOGI data collection and are testing out new workflows to capture this data. Many developing materials and training staff to engage patients to collect this data.** • **AHS** has conducted SOGI training for all staff and providers. MAs continue to collect SOGI data during intake. • **SVCMC** has standardized REAL data collection within their system. They have launched SOGI data collection for patients 18+ in Internal Medicine, Family Medicine, and Geriatrics was launched in early 2018. • **SMMC** enhanced the SO/GI questionnaire in their EMR and provided training for PCPs and the care teams. A workgroup was also established to develop training and marketing materials. • **UCI** has developed a new, streamlined workflow for its SOGI data collection within its EPIC system. • **UCSD** is standardizing workflows for the demographic documentation of REAL/SOGI data. • **VCMC** integrated SOGI questions into the annual questionnaire and creating an alert that provides passive prompting to staff has greatly improved the SOGI completion rate.
Chronic disease management	**Standardized practice protocols, pre-visit planning processes, chronic disease management programs and collaborative care models are being implemented for disease management.** • **CCRMC** is providing intensive population health management for patients with missing/uncontrolled diabetes at their diabetes innovation site through: 1) bulk lab ordering for patients with overdue HgA1c 2) follow-up calls by an LVN. As a result of this intervention, this site has achieved the **lowest rates of missing A1c tests in their system this period.** • **NMC** is focusing on improving care to diabetic patients, through the implementation of POC hemoglobin A1C testing. • **SCVMC** implemented an evidence-based chronic disease management program for diabetes, called Preventing Heart Attacks and Strokes Everyday (PHASE), in collaboration with Pharmacy, Endocrinology, and Primary Care. • The **SMMC** pharmacy is expanding collaborative care models for patients with poorly controlled DM, high blood pressure, on multiple medications and chronic opioids. The goal is to have a pharmacist in every primary care clinic by DY14 YE. • **UCSD** has adopted protocols for HTN and diabetes management, referral communication, and tobacco cessation. They are also providing targeted pharmacy and multi-disciplinary team outreach to meet metric goals. • **VCMC** implemented health fairs providing flu vaccinations and FIT tests (FluFIT) at several of clinics to optimize colorectal cancer screening performance. • **ARMC** created a variety of PDSAs to decrease increase compliance rates for the colorectal cancer screening and to decrease barriers to perform colonoscopies.

Improving the patient experience	**Systems are using quality improvement tools and developing new surveys to understand and improve key areas of the patient experience.** • **AHS** developed a Patient Experience A3 that focuses on: improving visit wait times, phone access and transparency. • **RUHS** has developed and rolled out a new real-time patient satisfaction survey across the organization to provide immediate feedback on the patient experience. • **ARMC** is putting together teams to roll out and market its patient portal in clinics.
DPH Strategies	**Example Activities**
Investment in IT platforms	**Systems are investing in and deploying population health management platforms to allow for more effective empanelment and patient outreach.** • **CCRMC** developed EHR capability to capture at-home blood pressure readings, and has provided training to providers at one health center on this workflow. • **SFHN** developed population health registries to identify patients for outreach to improve care around hypertension, tobacco use, IVD, and colorectal cancer screening. • **LACDHS** has deployed a population health platform that allows for more effective empanelment and identification of those with care gaps. • **SJGH** continued optimizing its EMR in the ambulatory care setting during the first half of DY14. SJGH will go live with its population health management platform (Cerner's HealtheIntent) during the second half of DY14, **which offers** tools to support patient stratification and the identification of high needs patients. • **UCLA** invested in technology to call patients who were out of date with their health maintenance. • **UCSF** refined panel management workflows across all of Primary Care with the use of automated software and workflow management technology. This led to significant improvements in outreach productivity and patient engagement across multiple preventive care topics. Results indicate that **staff are able to engage 3.86 times as many patients when they are assisted by technology.** • **UCSD** is utilizing health maintenance tools, registries and bulk patient portal communication. • **VCMC** developed depression reminders in the EHR to alert providers about when the next screening is due. This has resulted in improved assessments for depression remission.
Pre-visit planning	**PHCS are engaging in pre-visit planning processes to identify patients, care gaps and develop a management plan.** • **NMC** is working on chart scrubbing and huddling this DY. • **RUHS** sends proactive chase lists to clinics bi-weekly in order to help staff prepare charts and identify care gaps. • **SCVMC** has implemented pre-visit planning activities, which includes: each clinic working to initiate or refine huddles, and chart scrubbing activities. • **SMMC** implemented pre-visit planning program at 12 PC sites for diabetics and patients prescribed long-term opioids. PVPs are also identifying patients due for breast/colorectal cancer screening and sending out reminders. • **UCSF's** primary care clinics launched a daily huddle dashboard within the EHR where clinical staff review patients' preventive, chronic care, and immunizations needs.

Training and education	**Staff are being trained to screen and refer patients for substance abuse as and collect SOGI data.** • **SCVMC** provided LGBTQ terminology, SOGI work flow, health disparities, and communication practice sessions to clinic, language services and Valley Connection staff in order to prepare them for SO/GI data collection. • **CCRMC** designed and completed a comprehensive rollout of the new tool and conveying its importance through in-person training of staff and providers. Successful rollouts were conducted at all sites and messaging was reinforced throughout the reporting year with targeted training and coaching. At the end of this reporting period, CCRMC reported 92% compliance with SBIRT screening using internal guidelines. • In January, **VCMC** finished training designated staff and providers from all clinics on SBIRT screening, motivational interviewing, and referrals to specialty substance use treatment.
DPH Strategies	**Example Activities**
Disparity Reduction	**Systems are conducting outreach, undergoing trainings and developing stakeholder relationships to reduce disparities in their target populations** • **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.** SJGH is collaborating with the county's two managed MediCal health plans along with community partners to address blood pressure among African Americans**.** • **SMMC's** disparity reduction efforts have included data mining to identify at risk patients, dissemination of disparities data and outreach to specific patients in the affected population. They are also partnering with their African American patients to understand the barriers, challenges and opportunities that patients face in controlling their blood pressure. • **UCSF** has focused its disparity reduction efforts on bringing patients with uncontrolled blood pressure into clinic for a nurse or PCP visit. A standard clinical protocol for hypertension management has been developed to support providers across all UCSF primary care clinics. The tool kit includes standards for blood pressure measurement, diagnosis, medication management, timely follow up expectations, and guidance for special populations.
Leveraging data	**Systems are using performance data to drive improvements through dashboards and metric scorecards.** • **RUHS** sends performance data to clinic sites and providers (through monthly scorecards) in order to drive improvements. • **SMMC** have developed and installed QI boards with key metrics tailored for the outpatient setting at each clinic. • **VCMC** is providing on-demand information to clinic staff and providers to better equip clinic-level super-users to engage their staff and providers in improvement work.

Project 1.3: Ambulatory Care Redesign: Specialty Care	
DPH Strategies	**Example Activities**
Adoption & spread of eConsult/eReferral services	**eConsult/eReferral services are being rolled out across the primary care and specialty care clinics and one system is engaging in conversations with various health plans around reimbursement.** • **RUHS** is expected to complete its roll out of eConsult to all adult primary care clinics by April 2019. Preliminary data shows a **30% reduction in need for face-to-face appointments with specialists**. All primary care clinics are expected to be live with eConsults before May 2019. • Most **SCVMC** specialty clinics have now implemented eReferral/ active referral management workflows and builds. • **SJGH is** leading a community initiative to implement eConsult in San Joaquin County. eConsult was piloted with a subset of FQHC primary care providers and specialties. This will be rolled out to other PCPs in the second half of DY14. • **SMMC** continued live testing of its eReferral/eConsult platform with two specialists and seven primary care clinicians. • **UCD** continues to expand their eConsult visits and now has a total of 24 participating specialty clinics. • **UCSD** has expanded eConsults to twenty specialty divisions and patient satisfaction with eConsults is high. • **UCSF** instituted an eConsult program and now has 8% of all referrals from primary care to specialty care in the form of eConsult, and has engaged various health plans to develop reimbursement strategies for specialty care. • **VCMC** implemented an integrated eReferral management system that is part of and works seamlessly with the current EHR. The system tracks and monitors the referral progress and ensures accountability in all stages of the process by capturing real-time tracking data. eConsult now includes seventeen specialties.
Expansion of flu immunizations into specialty care	**Systems are increasing access to services, conducting patient outreach, providing training to staff and providers and engaging staff champions to increase flu vaccine rates.** • **CCRMC** provided **3% more flu shots** this year and doubled the number of flu shots administered in specialty clinics using the following tactics: 1) flu shot availability at all specialty clinics 2) provider and nurse education 3) patient outreach and reminders and 4) recruitment of a new flu champion. • **SFHN** designed and implemented training protocols for staff to offer flu vaccinations in specialty clinic. • To improve specialty clinic flu vaccine rates, **UCD** is completing outreach calls to patients, collecting their flu shot information when they present to clinics, and allowing patients to update their influenza yearly administration directly in MyChart.
Team based care	**Team based care continues to be a key strategy for reducing readmission rates and closing the referral loop with specialty care.** • **NMC** continues to work on their Team-Based Care model in specialty clinic and have organized clinical specialties into 5 teams with corresponding clinical support staff assigned to each team. • **SFHN's** Care Transitions Taskforce identified 6 major workgroups/areas to address 30-day readmission rate. This year, the heart failure workgroup launched an evidence-based discharge decision tool, started a monthly multidisciplinary heart team meeting to address social and medical needs of complex heart failure patients, and optimized heart failure post-discharge follow-up by launching a medication titration clinic.

Care coordination	**Care coordination teams are working to reduce unnecessary readmissions by identifying and addressing barriers through complex care planning and piloting complex care management rounds.** • **KMC** has a team dedicated to identify and remove barriers to quality care for patients transitioning out of inpatient stays. • **SFHN's** Department of Care Coordination launched a new care model that provides care coordination guidance for more efficient and anticipatory care planning. They are piloting daily complex care management rounds with multidisciplinary staff.
DPH Strategies	**Example Activities**
Workflow standardization and optimization	**Project activities include the piloting and spread of pre-visit planning processes and creating centralized workflows for primary and specialty care to ensure patients are receiving timely care.** • **NMC** has begun to implement NCQA's Patient Centered Specialty Practice processes and workflows. NMC's specialty clinic has also designed new pre-visit planning processes, which was piloted in its Sports Medicine specialty clinic in 2017 and is being spread to other clinical specialties in DY14. • **SJGH** established a centralized specialty and primary care scheduling center in DY13. Efforts are now focused on strengthening referral workflows and loop closure in order to complete the transition to a fully functional centralized scheduling/referral system during DY14. • **SMMC** implemented pathway two (P2) of the Model Cell with all primary care and two specialty clinics. P2 ensures that patients get their specialty needs by having the PCP consult the specialty guidelines, complete any workup/assessments and ensure patients are scheduled for any needed appointments. This pathway was spread to all primary care clinics in the first half of DY14 and two specialty clinics are also participating.
Leveraging data	**Dashboards are being used to provide real-time data and feedback on various metrics, allowing systems to make more timely decisions and develop improvement plans.** • **UCSF** has established a comprehensive access Qlikview dashboard, which displays real time access data by clinic. Referral turnaround measures were added to the dashboard during the demonstration year. • **SMMC** is working with Cerner Math on investigating system specific root causes/risk factors for readmission. They are currently process of examining high risk population cohort for appropriate intervention. As a parallel effort, they have designed a real time care transitions dashboard.
Expanding access to care	**Systems are improving access to care through: improved scheduling, improved discharge planning processes, development of a centralized call center, expanded treatment programs and through the implementation of non-traditional services.** • **LACDHS** is expanding outpatient access, providing earlier discharge appointments, creating a call center and improving the discharge planning process and assessment for discharge readiness. • **SFHN's** substance use disorder (SUD) champions have worked to launch and expand medication assisted treatment protocols for patient with alcohol use disorder and opioid use disorder before discharge. They have also partnered with a community based residential treatment program to discharge patients with SUD who are amenable and qualify for residential treatment directly on discharge. Finally, SFHN has partnered with SFHP to pilot an inpatient based addiction consult team to help provide teams and patients expert recommendations for patients with SUD. • **UCD** has expanded its MyChart Video Visit program has to 20 active clinics and is planning to offer video visits to all ambulatory departments in the coming year. The program offers Post-op follow-up; pre-op consultation; chronic care follow-up; primary care visits, and specialty pharmacy consultation and follow ups.

Project 2.1: Improvements in Prenatal Care	
DPH Strategies	**Example Activities**
Breastfeeding (BF) Promotion	**Systems are promoting breastfeeding through cross-sector collaborations, the hiring of new staff members and lactation consultants, provider and staff education, policy changes and by making donor milk more readily available.** • **CCRMC** began developing a **maternal prenatal documentation tab in the EHR to document BF practices** including patient preferences, risk factors, education, and BF history. In Sept. 2018, they implemented a **protocol** to give glucose gel to newborns to treat neonatal hypoglycemia in order to **better support exclusive BF and mother-infant bonding**. Nurses also began **peer-to-peer review on BF practices** to reinforce and sustain trainings. • **KMC** started a **donor milk program** to assist mothers that struggle with exclusive BF. A full-time **staff lactation consultant has also been hired** to provide 24/7 lactation support. • **SCVMC** has developed a practice of discharging all mothers from the hospital with **lactation follow-up appointments**. Lactation consults are also supporting the following areas: Neonatal Intensive Care Unit (NICU), Mother Infant Care Center, and clinics. Additional lactation consultants/ Comprehensive Perinatal Services Program (CPSP) **staff members were hired** to help educate and support the increased demand for mother and infant care. Currently, nine out of ten clinics have either an OB/GYN, Family Practice services, and/or a CPSP personnel who are educating and supporting the mothers in their lactation needs. • **SJGH** sought and received grant funding from First 5 San Joaquin to support **staff and patient BF training**. In response to increased demand, the maximum size of **BF classes was increased from 20 to 35 attendees** for English and Spanish. • To support lactation, **UCSD** has pursued the following strategies: development of a **lactation team** to work on quality improvement goals, improvement of prenatal **BF education**, development of a **transitional care pathway** for fragile infants to improve early BF access, development of an **app for BF information** and introducing **donor breastmilk** as supplement for term infants, and instruction of mothers in hand expression. • **UCSF** has improved access to **donor breast milk**, nurse **education**, and EHR documentation of reasons for supplementation. UCSF partnered with Evergreen Perinatal to offer **Baby Friendly Hospital education** for over 200 nurses during this DY. • A **VCMC** staff nurse successfully passed her International Board-Certified Lactation Consultant (IBCLC) examination in October 2018 and began providing **dedicated lactation consultation** to patients. • **ARMC** has hired a lactation consultant who is training all labor and delivery nurses.
Evidence-based practice	**Evidence-based tools and protocols are being implemented to reduce C-section rates and improve perinatal care.** • **NMC** has implemented evidenced-based practices to reduce C-section rates through use of a laborist model and midwifery in the hospital's OB Service. • **RUHS'** perinatal team has created tools to promote and support evidence-based practice, and developed a clinic-based perinatal registry to support staff in assisting pregnant and postpartum patients with appointments, referrals and resources.

Focus on patient safety	**TeamSTEPPS training has been conducted in a number of systems to promote patient safety and communication.** • **NMC** has implemented TeamSTEPPS training as part of a patient safety initiative. TeamSTEPPS principles were applied to post-partum hemorrhage simulation. NMC also updated policies, procedures and processes related to adverse events. • **UCSF** organized a TeamSTEPPS training for March 2018, which was designed to improve communication among providers, nurses, and other clinical staff. These tools were widely implemented across the perinatal care improvement initiatives, with a particular focus on quantitative measurement of blood loss and educing C-sections.
DPH Strategies	• **Example Activities**
Multi-disciplinary workgroups	• **UCD's** perinatal team continues to utilize the OB Best Practice committee as a forum to discuss and implement clinical change on the perinatal unit. The committee is made up of maternal fetal medicine physicians, obstetricians, family medicine physicians, anesthesia physicians as well as nurses from labor & delivery and postpartum. • **UCSF** has a multi-disciplinary PRIME Perinatal Steering committee, as well as a Baby Friendly Working Group with representation across Obstetrics, Pediatrics, Nursing, and the Office of Population Health.
Leveraging data	**Registries are being built to identify and provide targeted outreach to patient panels in order to improve prenatal and postpartum care. Dashboards are also being used to drive performance improvement.** • **SFHN** outpatient efforts are focused on creating registries and dashboards to improve panel management for prenatal and postpartum care. SFHN has successfully implemented an electronic notification system to improve scheduling of postpartum appointments. A postpartum registry was built to identify patients who have not attended a postpartum appointment and managers are trained to support clinics across our network in standard work for panel management to track and outreach to patients to increase timely postpartum care. • **UCI** continues to distribute monthly dashboards showing performance on all perinatal quality measures, to guide improvement efforts in a timelier manner.
Baby Friendly Designation	***Achieved:*** AHS ARMC RUHS UCSD (Hilcrest, Jacobs Medical Center) UCI UCLA (RRMC achieved in DY12, SMH achieved in DY13) NMC ZSFG VCMC SJGH ***In progress:*** **Development phase:** KMC (completed) **Dissemination) phase:** UCSF, UCD, **Designation phase:** SCVMC, CCRMC

Project 2.2: Care Transitions: Integration of Post-Acute Care	
DPH Strategies	**Example Activities**
Multi-disciplinary workgroups and cross-sector collaboration	**Interdisciplinary workgroups and cross-sector collaboratives are focusing on improving the patient experience across the continuum of care.** • **AHS** is developing an interdisciplinary readmissions working group, which is currently focused on improving the care management program. • **SCVMC's** Patient Satisfaction Across Continuum of Care (PSACC) and Customer Service Department (CSD) continues to sponsor the SCVMC Patient Experience Champion Program (PEC), which is designed to cultivate patient-centered care. • **UCLA** has brought together a committee that is charged with evaluating and crafting a strategy to effectively reduce the readmission rate. The committee is focusing on: Outpatient Optimization, Care Coordination, and Transitions of Care. • **SJGH** initiated a multi-disciplinary patient experience workgroup in DY13. Initiatives to date include: providing information folders to patients prior to discharge to support their transition of care needs, restructuring care management to provide more frontline support to patients, improving quality of information provided to patients related to medicine and pain management and daily leadership rounding to learn and address needs of patients on the floor. • **UCSD** engaged a multidisciplinary group including pharmacists, pharmacy technicians, physicians and nurses to standardize the medication reconciliation process across all clinic locations. • **UCSF** continues to engage in 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. • **SFHN's** Care Transitions Taskforce includes representatives across the continuum of inpatient and outpatient care, including nurses, pharmacists, physicians, social workers, and patient navigators. The Taskforce develops best practices in care coordination, care team communication and complex care management. • **SMMC** convened a Committee comprised of various disciplines including Case Managers, Inpatient Physicians, Nurses, Pharmacists, Primary care and Care Transitions team members in DY12. This Committee meets monthly to work on coordination with the PCMH as well as with the recently-initiated ED triage intervention. • **NMC's** Inpatient Discharge Process workgroup focused on improving patient education related to readiness for discharge. They have continued to refine and customize a process for patient education related to home medications. The updated process was implemented in April 2018.
Patient satisfaction	**Systems are developing new processes and campaigns to engage patients around satisfaction surveys.** • **AHS** is using nursing rounds to improve patient satisfaction scores related to care transitions • **UCLA** is using a new process to engage patients post-discharge, including email surveys. • **CCRMC** developed an awareness campaign called "We're Listening" with flyers and posters to amplify this effort around patient preferences.
Leveraging data	**Strategies include the development of dashboards and decision support tools to support effective interventions.** • **SCVMC** has developed dashboards to provide clinicians with electronic tools for effective interventions. • **UCD** partnered with EMR to develop a Med Rec Acuity Score to identify patients at high risk for mediation related errors. • **UCSD** has implemented a medication review decision support tool within the EMR, which has led to the reliable documentation of medication reconciliation at post-discharge visits.

DPH Strategies	Example Activities
Patient engagement	**Post-discharge phone calls are being used to provide outreach and aid care transitions post-discharge.** • **RUHS** is in the planning phase of implementing post-outreach phone calls via a Cipher Health robocall platform. This outreach program will allow RUHS to follow up on 100% of patients' post-visit, procedure, and discharge. • **KMC** staffed an Acute Care Transitions team to provide 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. • **UCSF's** Care Transitions Outreach Program (CTOP) calls all patients after discharge home, addressing concerns such as symptoms, issues with prescriptions/medications, and follow-up plan.
Improving access to care	**Centralized call centers, increased staff and new practice locations are among the strategies to improve access to care.** • **UCI** is opening more practice templates, adding physicians and new practice locations across Orange County. • **SFHN** is piloting a centralized call center for one clinic within the system.
Workflow standardization	**Standardized scripts have been developed to reduce barriers and enhance communication around discharge.** • **UCD** developed a discharge talking-points script for both pharmacists and nurses to help standardize discharge education. • **SFHN** implemented a (1) standard script, (2) color code to transmit discharge status, and (3) will be communicating discharge status to charge nurses hoping to improve communication and reduce barriers. They are also implementing evidenced-based guidelines around heart failure, which is a major contributor to readmissions)
Care coordination/care transitions	**Strategies in this project area include: hiring more staff to provide care coordination and navigation; identifying high risk patients and facilitating care transitions; developing protocols and discharge materials; conducting post-discharge follow-up calls; and creating centralized care management programs.** • **RUHS** added care transition information to the communication boards in the patient rooms; staff and providers were trained on care transitions and the importance of providing clear, concise follow up instructions; A Safe at Home Program was implemented which identifies high-risk patients that require an in-person patient navigator visit prior to discharge. The Care Transitions team is currently developing a discharge folder to facilitate organization of patients' hospital documents as well as a comprehensive discharge checklist. • **SJGH** has a population health management team of 5 clinical nurses and 4 non-licensed staff which provide: 1) care coordination; and 2) care navigation support following ED or inpatient stays. • **SCVMC's** Complex Care Management Program was recentralized and managers were recruited. New nurses were hired with goal of at least one nurse per clinic. • **UCSF** has piloted Telehealth visits as an effective post-discharge follow-up approach at selected clinics. • **NMC** is developing plans to implement follow-up appointments for Med/Surg medical and family medicine patients. • **UCI** Care Management Associates assist in obtaining appointments post discharge. A pilot will be tested to provide this service within the Central Authorization Call Center. UCI also has five health coaches that provide navigation services and conduct follow-up calls to ensure patients have a PCP appointment within 7 days of discharge. • **SFHN** improving care coordination by implementing an inpatient complex care management model.

Project 2.3 Complex Care Management for High Risk Medical Populations	
DPH Strategies	**Example Activities**
Care coordination	**Systems are creating a tiered approach for interventions based on risk to ensure patients are receiving the appropriate level of support and care coordination.** • **AHS** created a tiered system that calibrates the "dose" of the complex care intervention patients received as way to ensure patients receive appropriate support while also building independence. • **CCRMC's** PRIME pilot program, Care Connect, continues to serve as a test bed for high acuity population care management. This program was transitioned to a social needs model with a team that includes a community health worker, medical social worker, registered nurse, and alcohol and other dependencies social worker. Strategies are being discussed to expand the reach of Care Connect to patients throughout the county on an as-needed basis. • **LACDHS** received NCQA Medical Home recognition in their Ambulatory Care Network last year, which helped to ensure providers are committed to accepting handoffs from the inpatient setting. • **UCD's** multi-disciplinary care team uses tiered interventions that are deployed based on risk and ensures systems and care teams are in place to support system navigation, and post-discharge care following ED and hospital admissions. • **ARMC's** High Utilization Patient Care Outreach program utilizes RN Care Manager's to educate patients, their families and caregivers and provide follow-up within 48 hours after discharge.
Patient engagement	**Systems are identifying and conducting outreach for patients in need of treatment or post-discharge follow-up.** • **AHS** expanded complex care management identification and enrollment activities to hospital admissions as a way to increase patient engagement, maximize outreach efforts and improve provider satisfaction. • **KMC** provides phone outreach to individuals non-compliant with metric specifications to schedule appointments so that the appropriate tests and screenings can be performed. • **VCMC** places automated calls to patients following discharge to discuss (1) patient improvement/decline (2) post-discharge appointments (3) discharge instructions and (4) filling prescriptions. Discharge planning nurses monitor for responses that indicate an issue that could result in a negative health outcome, including readmission. • **SFHN** has developed a population list to recruit patients into its primary care based complex care management programs.
Collaboration with other waiver areas	**Systems are refining strategies so that data can utilized and leveraged across other waiver programs.** • **CCRMC** collaborated with the Whole Person Care (WPC) team for care coordination and to prevent redundancies. They leveraged their electronic health record system for shared documentation between the PRIME 2.3 team and WPC to improve care coordination.

Improving access to care	**Systems are redefining workforce roles and responsibilities, increasing staffing and developing new medical homes to better meet patient treatment needs and increase their capacity to provide timely access to care.** • **AHS** consolidated referral criteria and reviewed best practices for staff roles and staffing ratios in order to increase capacity to serve more patients. • **NMC**'s Emergency Department Case Management is now staffed 7 days a week, allowing for improved communication with the Ambulatory Case Manager and resulting in fewer readmissions. • **KMC** has partnered with one of their managed care providers to create two PCMH clinics to better meet the treatment needs of high-utilizing patients.
DPH Strategies	**Example Activities**
Training and education	**Staff are being trained on to refer patients to community resources for social determinants of health and disease management.** • **AHS** Increased staff competencies through trainings related to community resources for substance use, housing, disease management. Team are also provided with weekly trainings on subjects such as: motivational interviewing, trauma informed care and chronic disease management.
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.** • **AHS** is developing dashboards to monitor total team capacity, individual staffing ratios, process and outcome measures • **LACDHS** has invested in an enterprise-wide Patient Registry and Empanelment system that is integrated into the EHR, allowing for tracking of chronically ill patients and providing opportunities for addressing concerns and gaps in care. • **SFHN** has implemented the Emergency Department Information Exchange (EDIE) platform. The Care Management Programs are actively utilizing EDIE to track their patient's use of emergency rooms and inputting standardized care plans into EDIE to quickly communicate with healthcare providers in the various EDs. • **UCD** and **UCLA** are using predictive tools to identify, risk stratify and improve the timely delivery of interventions. • **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 risk scoring performance through the addition of social determinants and chronic disease registries.
Workflow redesign	**Documentation is being streamlined to improve data capture and record accuracy and best practice algorithms are being included in workflows to better manage chronic conditions.** • **RUHS** developed algorithms for best practice for a number of complex conditions, which includes RN workflow, medication titration protocols and patient education to enhance self-management. • **VCMC** has worked to streamline documentation at discharge to provide better patient education and accuracy of records and to improve follow-up with aftercare through ambulatory providers. • **SCVMC's** Complex Care Management Program (CCMP) underwent another redesign and was subdivided into primary care complex care and specialty care programs. They also plan to recruit more than 20 community workers to help manage complex patients, and high utilizers of multiple services.
Team based care	**Systems are embedding multi-disciplinary teams in clinics to manage behavioral, physical health & complex diseases.**

	• **UCI's** ACO developed a clinical group of health coaches, coders, RNs, LCSWs, NPs and PharmDs to co-manage high risk patients. Workflows are being developed to ensure the high-risk groups can be referred seamlessly to the care team. • **UCSF's** complex care team is expanding psychiatry resources and are building capacity to enhance palliative care skills. • **UCSD's** multi-disciplinary Care Coordination staff has been (1) socializing the integrated care team model across the enterprise (2) customizing the high-risk workflows based on roles (3) enhancing the coordination between hospital transition teams and the high-risk program. • **RUHS** is refining roles within the care management teams to focus on case rate performance. The teams now implement screening for behavioral health and substance abuse disorders, provide proactive patient outreach initiatives, and conduct care planning to document interventions with BH and primary care providers.