Project 1.1: Integration of Physical and Behavioral Health	
Key Themes	**DPH Examples**
Strengthening & standardizing performance improvement	**DPHs are standardizing and scaling screening tools to support behavioral health integration.** • **ARMC** expanded its alcohol and substance abuse screening to its Behavioral Health Integration and Complex Care Initiative in DY14 and plans to continue expansion to all primary care patients. • **RUHS** expanded its behavioral health integration to any patient in need of assistance from a psychiatrist, licensed clinical therapist, or behavioral health or substance abuse services. • **CCRMC** continues to reinforce best practices for reliable and consistent screening across our health centers with training, coaching, in-person consultations and emails. • **SJGH** has strengthened its pre-visit planning by flagging patient gaps in these metrics in Cerner. This process was recently expanded to all primary care clinics. • **SMMC** has implemented depression screenings at four clinics, and has screened 6500 PRIME eligible patients. • **UCSD** is screening all primary care patients, has implemented follow-up for depression using on-site behavioral health providers and patient registries, and is intervening with patients who have potential substance use disorders using the SBIRT model. • **UCD** has expanded its behavioral health services in primary care to support patients with major depression, which includes: universal screening, electronic consultations, ambulatory care management, the collaborative care model for depression, embedded psychiatry consultants and PCP education.
Investment in IT & data analytics	**Systems are building alert tools in the EMR to track and address gaps in care to better support patient outcomes.** • **ARMC** has improved tracking of patient outcomes through the integration of a new healthcare information exchange portal. • **RUHS** implemented the Whole Person Health Score (WPHS) Assessment tool, which evaluates a patient's physical and emotional health, resource utilization, socioeconomic status, lifestyle and potential barriers. • **VCMC** launched an intranet site that highlights metrics prioritized for improvement work and includes monthly performance data by clinic with links to quick references that are designed to assist staff and providers with understanding key areas of care, documentation, and coordination. • **SCVMC** completed the discovery phase for building in routine lab reminders for patients on anti-psychotics into the EMR, which is expected to launch in DY15. • **UCSD** implemented a suicide risk alert banner in the EHR to support PCP response to significant patient suicidal ideation.
Implementation of new processes & work flows	**Systems are consolidating screening and referral processes and incorporating mental health and support resources into care plans to support more efficient and effective behavioral health management.** • **CCRMC** launched a universal behavioral health referral process that streamlined six referral processes into one and triages referrals to internal and external providers for faster response. • **NMC** has identified and incorporated additional mental health and social support resources into their patient care plans. • **SCVMC** implemented the consolidated brief screening tool, Staying Healthy Assessment (SHA)-Annual, that meets DHCS, CMS PRIME and WPC health screening mandates across all internal medicine and family practice clinics. In May, SCVMC launched a new population health operational tool for depression management. • **UCD** piloted new depression screening workflow and follow-up plan documentation tools in the EMR, which enhanced workflows across the primary care clinics.

Project 1.1: Integration of Physical and Behavioral Health	
Key Themes	**DPH Examples**
	• **UCLA** also developed workflow and screening processes supporting SBIRT by drawing upon existing protocols for depression screening. • **UCSD** rolled out a process improvement project at one clinic, which resulted in increased and more reliable screening.
Enhanced patient outreach	**Systems are providing targeted outreach and increasing access to care for patients in need of behavioral health or chronic disease management.** • **RUHS** has expanded its complex care, behavioral health management triad teams to include a Community Services Assistant to provide patient outreach. • **SJGH** is offering weekly diabetes self-management class for patients with uncontrolled diabetes (HbA1c >9.0%).
Workforce development	**Systems are hiring team members to increase access to care and support the addition of new services.** • **CCRMC** hired a full-time psychiatrist at one clinic, and has an on-call psychiatrist available for consultations, increasing call response by three-fold over the past reporting year. • **UCSF** is expanding the staff and availability of depression collaborative care teams. UCSF's Population Health team hired an NP specializing in opioid addiction to address substance use screening and treatment. • **VCMC** launched the Addiction Medicine Specialty Fellowship to expand the direct delivery of Medication Assisted Treatment and to provide technical and eConsult support to primary care providers. • **UCSD** increased their behavioral services team to account for the expansion of services to two new clinics this year.
Improved coordination & partnerships	• **KMC** partnered with a managed care provider to create two PCMH clinics to better meet the needs of high-utilizing patients.
Investment in infrastructure	• **SCVMC** purchased two additional hospitals in March, preserving critical services for patients in the SCVMC network.
Challenges	• **Staffing:** Staff turnover and changes to the staffing environment due to competing resources made it difficult to sustain metric performance.

Project 1.2: Ambulatory Care Redesign	
Key Themes	**DPH Examples**
Improved coordination & partnerships	**DPHs are developing partnerships and expanding collaborative care models to manage patients with chronic diseases and support best practices.** • **RUHS** partnered with the Center for Care Innovations through a Kaiser Permanente grant to optimize the management of patients who have uncontrolled blood pressure, identify barriers to optimum care through utilization of the RUHS "whole person health score" and develop best practice strategies for blood pressure control. • **UCD** Pharmacy is expanding collaborative care models for patients with poorly controlled diabetes, high blood pressure, multiple medications and chronic opioids with the goal of staffing a pharmacist in every primary care clinic by DY14 YE.
Enhanced patient outreach	**Systems are developing registries and chase lists to identify patients who are non-compliant with metrics for enhanced outreach through orientation letters, bulk orders and portal communications.** • **CCRMC, UCLA and KMC** are conducting targeted phone outreach for patients non-compliant with metrics. • **CCRMC** opened a walk-in blood pressure kiosk, which is staffed by a nurse and served more than 600 patients during the 3-month pilot. • **NMC** is identifying preventative in-reach and outreach opportunities to increase non-emergent access to care through: patient orientation letters, SSRS reports, and increased coding specificity. • **RUHS** is testing several disease specific registries within its population health platform to allow for more centralized screening and preventative care outreach. Clinics are also receiving weekly proactive chase list of patients with care gaps. • **UCSF** refined outreach workflows across all of Primary Care with the use of automated software and workflow management technology, leading to significant improvements in productivity and patient engagement. • **SFHN** has developed population health registries to support the identification and outreach for patients in the following areas: hypertension, tobacco use, IVD, and colorectal cancer screening. The Primary Care team also designed clinical and communication tools that are culturally appropriate and informed by patient advisors. • **VCMC** organized health fairs to provide flu vaccinations and FIT tests ("FluFIT") at several clinics. • **UCSD** is utilizing bulk patient portal communication, real-time ad hoc reporting, and multi-disciplinary team outreach. • **UCD** implemented pre-visit planning (PVP) program at 12 primary care sites for patients with diabetes and chronic opioid use. The program uses bulk orders, send messages via the patient portal and flags outstanding metrics via a daily patient registry.
Workforce development	**Systems are restructuring teams to promote improved care coordination through preventative screenings, chronic disease management and other health maintenance topics.** • **ARMC** began training its staff around the rollout of its patient portal. • **UCSF** restructured the population health outreach team and hired a centralized group of Health Care Navigators, which will leverage technology-based outreach and allow UCSF to provide care coordination for patients across many clinics. • **SMMC** has developed roles that allow team members to work at the top of their license and meet a range of patient needs such as preventive screenings, chronic disease management, new patient intake, and provision of behavioral health services. • **AHS** shared motivational interviewing techniques with providers and provided in-depth training to a small subset of clinicians. • **SCVMC** filled vacancies and created new positions within the diabetes care team. SCVMC also began a new round of SOGI trainings for specialty clinics this DY, which will continue through DY15. • **UCD** established a workgroup to develop SOGI training and marketing materials, and training was provided for primary care providers and care teams in alignment with the go-live of the enhanced EMR tools.

Project 1.2: Ambulatory Care Redesign	
Key Themes	**DPH Examples**
Investment in IT & data analytics	**Systems are utilizing EHR tools to identify, monitor and address care gaps.** • **NMC** is utilizing its EMR to develop reports that improve workflows and close gaps in care. • **RUHS** has developed Best Practice Advisory alerts to identify care gaps, Smart Data Elements for improved data capture, and Smart Forms to streamline and facilitate care teams, screenings, assessments, follow-up and documentation. • **UCSF** leverages Epic's Health Care Maintenance module to help clinic staff monitor overdue preventative and chronic care topics. During DY14, depression follow up was added to the Health Maintenance banner and other enhancements were made to this tool to streamline staff workflows for closing care gaps. UCSF also developed 9 preventive and chronic care registries within Epic. In 2019, **UCSF** pursued advanced integrations between Epic registries and the automated outreach software to facilitate and scale patient engagement interventions. • **VCMC** used the National Research Corporation to better analyze patient experience and create targeted campaigns to increase response rates, engage providers, and to perform service recovery for unsatisfied patients. VCMC also developed EHR alerts to support SOGI completion and to guide provider clinical decision support.
Strengthening & standardizing performance improvement	**DPHs are conducting quality improvement activities to refine and sustain performance improvement efforts and are successfully adopting and disseminating disease management and data collection workflows across their systems. Systems are seeking PCMH recognition to formalize care coordination models.** • **UCSD** standardized workflows and cultural competencies for the demographic documentation of race, ethnicity, sexual orientation and gender identity. Clinics have also adopted and disseminated protocols for hypertension, diabetes management, referral communication, and tobacco cessation to support evidence-based care. • **SCVMC's** Complex Care nursing team and Primary Care Behavioral Health staff have successfully rolled out group medical visits for controlling blood pressure across most clinics. Workgroups meet to discuss and refine depression, depression remission, and SBIRT screening in order to they become standard and sustainable practice. • In DY14, **UCD** renewed NCQA PCMH recognition for all PC clinics and **SJGH** achieved PCMH recognition. • **UCSD** conducts rapid quality improvement cycles for diabetic care, cardiovascular care, and referrals. UCSD plans to sustain current efforts by leadership by engaging physician champions and conducting targeted pharmacist outreach. • With a change in Ambulatory Care Services leadership, **SJGH** began a process of strategic planning and significant organizational restructuring and transformation to better manage its resources to improve primary care access and quality.
Challenges	• **IT Infrastructure:** transition to new enterprise-wide EHR; Data integration challenges; Limited EHR capability to capture data at the level necessary to fulfill reporting requirements. • **Competing Priorities and Resources:** Limited resources available to complete multiple, large scale priorities. • **Growing Number of P4P Measures:** Challenge to ensure targets are being met for growing number of pay-for-performance measures

Project 1.3: Specialty Care Redesign	
Key Themes	**DPH Examples**
Improved coordination & partnerships	**eConsult is being adopted and spread across primary care and specialty care clinics, leading to a significant decrease in patient wait times and a reduction in the need for face-to-face appointments.** • This DY, **RUHS** expanded its multi-county eConsult Initiative for fourteen service lines across the primary care network, with plans to add additional services lines in the future. Preliminary data showed an initial 30% reduction in the need for face-to-face appointments with specialists, however that reduction is now around 15%. • **SJGH** has been leading a community initiative to implement eConsult in San Joaquin County's safety net. eConsults have implemented in two FQHCs for 15 specialty lines this DY. • **SCVMC's** eConsult process has significantly contributed to a decrease in patient wait times from 90 days in 2014 to 21.4 days for 2019 (76% reduction). This new system-wide referral system is part of the Innovative County of Santa Clara Health Systems 2020 program. • This DY, **SMMC** expanded live testing of its eReferral and eConsult platform to all medical and surgical clinic specialties. • **UCD** has expanded eConsult to 24 participating clinics and now includes all diagnostic categories, which has increased the numbers of referrals. The MyChart Video Visit program has also expanded to approximately 20 active clinics with plans to offer video visits to all ambulatory departments in the coming year. • **UCLA** has improved non-face to face encounters by expanding eConsult into additional specialties. • **UCSF** engaged various health plans to develop reimbursement strategies for specialty eConsults as a way to ensure sustainability of these innovations. • **SFHN's** central eConsult system is being utilized by several departments across the network for care coordination.
Enhanced patient engagement	**Systems are conducted targeted outreach to schedule patient appointments and increase flu vaccine rates. Systems are also engaging patients through the use of patient portals.** • **UCD** continues to improve the influenza vaccination rates in the specialty clinics by completing outreach calls to patients collecting their flu shot information when they present to clinics, and now allowing patients to update their influenza yearly administration directly in the patient portal. • **SCVMC's** patient portal has allowed patients the ability to update their demographics before check-in and self-schedule follow up appointments and urgent care appointments. SCVMC is also conducting proactive patient outreach to schedule specialty care appointments.
Investment in IT & data analytics	**Workgroups are optimizing electronic communications and leveraging data analytics to monitor progress, identify trends and improve performance.** • For DY14, the **NMC** Specialty Clinic practice workgroup continues to optimize electronic communications and workflows for non-face to face specialty referrals. • **VCMC's** eReferral management system in Cerner allows for real-time tracking and monitoring of referral progress, allowing for the creation of reports that show volume, referral patterns, and performance that can be used to identify trends and inform design strategies to improve referrals and access. • **AHS** will implement an integrated EHR in early DY15, which will streamline the referral process and PCP-specialty communication by: improving tracking and accountability of referral response timeframes; improving closed-loop communication between referring and specialty providers; and improving specialty access through eConsult.

Project 1.3: Specialty Care Redesign	
Key Themes	**DPH Examples**
Strengthening & standardizing performance improvement	**DPHs are strengthening referral and loop closure workflows through centralized scheduling centers, EHR tools and engaging leadership. Systems are also applying lessons learned to develop standard work, train staff/providers, provide patient outreach and use data to drive performance improvement for vaccine rates.** • **SJGH** established a centralized scheduling center in DY13 to merge both primary and specialty care scheduling, and spent much of DY14 focusing on strengthening referral workflows and loop closure and completing the transition to a fully functional centralized scheduling/referral system. • **RUHS** has implemented standardized workflows in specialty clinics for closing the referral loop after a successful pilot in GI clinic. This new process has been embedded into the EHR in order to enhance sustainability and includes sending an auto-generated letter with a copy of the progress note to the referring physician. • **SCMVC**'s continuous quality improvement and standardization of Valley Specialty Center care delivery has been strengthened with the engagement of strong operational leadership. • **CCRMC** was able to increase flu vaccination rates by 10% and administer twice as many flu shots at specialty clinics, by applying previous lessons learned. Strategies included: patient outreach via birthday letters and automated phone calls and updates to health maintenance workflows in the EHR so that providers continue receiving prompts to offer the flu vaccine if the patient postpones. • **SFHN** is driving performance improvement in this project by: using Fishbone diagrams to determine key barriers to successful implementation of flu vaccines, generating and sharing flu vaccination rates for specialty care clinics at daily performance improvement huddles, and leading quarterly meetings with nurse managers to discuss best practices.
Challenges	• **Misalignment with reimbursement structure:** low use of eConsult due to lack of financial incentives for specialists who are FFS contractors. • **IT infrastructure:** EHR limitations has limited the spread of piloted workflows to other specialty clinics; Delays in expansion of telemedicine services, limiting the reach of specialty touches with this technology. • **Staff/Provider turnover** • **Difficulty achieving year-over-year improvement for P4P metrics**

Project 2.1: Improvements in Prenatal Care	
Key Themes	**DPH Examples**
Implementation of new processes & work flows	**Systems are developing new policies to promote breastfeeding, make donor milk more readily available and reduce formula administration.** • **NMC** implemented the use of a sepsis screening tool which is used when patient is admitted and each shift thereafter until discharge. The team developed a policy and protocol for the screening and service-wide education was conducted. • This DY, **UCI** developed a policy and procedure for the utilization of banked breast milk implemented. A process was also developed where providers can document breast feeding education given, and a report was created to identify providers that are out of compliance. UCI also revised guidelines for the High-Risk Infant Hypoglycemia protocol to add use of glucose gels for treatment of hypoglycemia in order to support exclusive breastfeeding. • **UCSF** completed activities for the Baby Friendly Dissemination phase including: infant breastfeeding policy roll-out, staff training and data collection. • **VCMC** implemented new policies to increase breastfeeding in the hospital, including rescheduling newborn tests to allow nighttime feeding and the addition of a glucose gel protocol for hypoglycemia treatment. • **UCSD** developed a transitional care pathway for fragile infants to improve early breastfeeding access and introduced donor breastmilk as supplement for term infants.
Workforce development	**Systems are promoting breastfeeding by hiring of new staff members and lactation consultants and engaging in partnerships to allow for enhanced staff training and skill development. Education is being integrated into nursing competencies to promote continued metric sustainability.** • **ARMC** hired a lactation consultant to drive improvements in inpatient and outpatient patient education. She began providing training in June and has since expanded that training to include all L&D nurses. • **CCRMC** has trained nearly all nurses and 74% of physicians in breastfeeding practices, since November 2018. To support training, CCRMC produced a handout and video on breastfeeding practices for new employee orientations, and nurses began peer-to-peer review on these practices to reinforce trainings. • **KMC** hired full-time staff lactation consultants to provide 24/7 coverage lactation support. • **NMC** conducted focused provider and staff education for 1:1 physician simulations, timely treatment of hypertension, GNOSIS fetal monitoring competency assessment and post-partum hemorrhage annual education. • **RUHS** began offering additional Breastfeeding 101 classes, along with the opportunity to shadow a lactation consultant to increase lactation education for perinatal clinic staff. Collaboration with Riverside WIC provided the opportunity for two perinatal nurses to attend the IBCLC preparation course. This fall, RUHS will also hire additional OB/GYN physicians who will solely be based at RUHS, rather than splitting their time with other facilities. • **SJGH** received grant funding from First 5 San Joaquin to support staff and patient breast-feeding training. In addition, Labor Support training became a required class for all labor staff during DY14. • To promote sustainability of PRIME outcomes, **UCSF** integrated training on breastfeeding and OB Hemorrhage into the Annual Skills Review for all nursing staff. UCSF partnered with Evergreen Perinatal to offer Baby Friendly Hospital education for over 200 nurses during this DY. • **VCMC** nurses with CLEC or IBCLC were given dedicated time to do patient education for breastfeeding in the hospital. • **SCVMC** hired additional lactation consultants/Comprehensive Perinatal Services Program staff to meet the increased demand. Now, 9 of 10 clinics have dedicated OB/GYN staff educating and supporting the mothers in their lactation needs.

Project 2.1: Improvements in Prenatal Care	
Key Themes	**DPH Examples**
Investment in IT & data analytics	**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 in tracking and providing outreach to patients for timely postpartum care. • **UCI** distributes monthly dashboards showing performance on all perinatal quality measures, to guide timelier improvement efforts. • **SCVMC** formed an EMR team dedicated to OB/GYN analytics.
Strengthening & standardizing performance improvement	**Systems are embedding new processes by integrating algorithms, engaging staff champions and promoting best practices through evidence-based training modules and learning collaboratives.** • **NMC** and **CCRMC** have implemented TeamSTEPPS training for enhanced performance and patient safety. NMC is applying these principles to post-partum hemorrhage simulation and adverse event response processes. • **UCD** reviews all fallout cases of NTSV c-section, and developed and implemented an algorithm for management of Category II fetal heart rate tracing with decelerations to improve and standardize the management of this condition. • **UCSF** improved its exclusive breastfeeding to above 80% in DY14 by improving access to donor breast milk, scaling Baby Friendly training, and requiring EHR documentation of reasons for supplementation. • **SCVMC** has formed a Lactation Taskforce and recruited lactation champions SCVMC is also participating in the DHCS learning collaborative to share improvements and pathways to success with the other DPHs. • **UCSD** developed a lactation team to work on quality improvement goals.
Enhanced patient engagement	**Systems are increasing access to care through new clinics services and appointment window. Patients are also being given access education through classes, support groups and mobile technology.** • During the end of DY14, **SJGH** established a one-day per week lactation clinic for scheduled and walk-in appointments, and will begin offering outpatient lactation clinic services during the first half of DY15. To improve access to perinatal care, SJGH added additional OB/GYN clinic hours on evenings and Saturdays during the second half of DY14. • **VCMC** began providing breastfeeding help for newly discharged mothers in its outpatient clinics. • **SCVMC** extensively advertised lactation support groups and classes in its clinics, and began discharging all mothers from the hospital with lactation follow-up appointments. • **UCSD** is developing an app for breastfeeding information and providing instruction to mother on hand expression.
Improved coordination & partnerships	**Multidisciplinary workgroups are being convened to discuss and implement clinical changes, and systems are working with outside providers to coordinate care for prospective patients.** • **KMC** implemented better tracking procedures for patients in prenatal and postpartum phases, including working closely with outside providers to proactively identify prospective maternity patients, to ensure they receive the care they need. • **UCD's** perinatal team continues to utilize the OB Best Practice committee, made up of maternal fetal medicine physicians, obstetricians, family medicine physicians, anesthesia physicians, and L&D and post-partum nurses, as a forum to discuss and implement clinical change on the perinatal unit.

Project 2.1: Improvements in Prenatal Care	
Key Themes	**DPH Examples**
Baby Friendly Designation	***Achieved:*** AHS ARMC RUHS UCSD UCI SCVMC (achieved January 2019) UCLA NMC ZSFG VCMC SJGH ***In progress:*** **Development phase:** KMC (completed) **Dissemination phase:** UCSF, UCD **Designation phase:** CCRMC
Challenges	• **Documentation:** discrepancies between actual clinical events/outcomes and assigned ICD codes, requiring retroactive correction of ICD codes and labor-intensive coaching of providers around proper documentation. • **Difficulty recruiting staff** • **Adoption and buy-in around donor milk policies**

Project 2.2: Care Transitions: Integration of Post-Acute Care	
Key Themes	**DPH Examples**
Improved coordination & partnerships	**Systems are using a team-based approach to aid care coordination efforts, reduce barriers and ensure a smooth transition of care post-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 inpatient and into primary care setting. KMC has also partnered with one of their managed care providers to create two PCMH clinics to better meet the treatment needs of high-utilizing patients. • **RUHS'** Integrated Care Management department established a quarterly symposium with local Skilled Nursing Facilities to address barriers to transitions that may lead to readmissions from these facilities. • **SFHN** is improving and standardizing multidisciplinary rounds to emphasize coordination, communication and team-based care, by assessing and addressing complex medical and social needs of patients to improve care after discharge. SFHN is also implementing an inpatient complex care management model. • Five **SJGH** clinical nurses and three non-licensed staff continue to provide: care coordination and care navigation support following ED or inpatient stays. • **UCI** has added three additional health coaches to its previous five to assist patients with care navigation, transition of care between inpatient and outpatient and with behavior change. • **SCVMC** implemented a multi-pronged approach to promote coordination of care and reduce duplication of services, through collaborative planning and emphasis on the patient-experience. • **ARMC** teams discharging patient patients from an inpatient stay work with clinics and the Call Center to ensure that patients receive a follow-up appointment within 7 days.
Implementation of new processes & work flows	**Systems are developing disease specific interventions and programs for high risk patients, conducting discharge phone calls and outreach and developing protocols to assess readiness for discharge.** • In January 2019, **NMC** implemented a new process where a Care Navigator is responsible for making follow-up appointments for Med/Surg medical and family medicine patients prior to discharge. • **SFHN** is piloting a centralized call center for one of our clinics. SFHN is also focusing on creating diagnosis specific interventions, including evidence-based inpatient medication guidelines a diurese-to-euvolemia algorithm for patients with heart failure. • **UCD** developed a talking-points script utilizing both pharmacists and nursing staff to standardize discharge education. • **VCMC** introduced a new Discharge Pharmacy Consultation program, where a pharmacist goes to the bedside and reviews medications for patients with polypharmacy, patients on high-risk medications and patients who are at risk for readmission. • **AHS** Care Transition Managers are using iRound, a technology-based solution, to ensure patient discharge readiness. Nursing implemented a new pictorial document of medication information that is reviewed with patients during their stay to ensure patient understanding of their medications and improve post-discharge medication compliance. • In DY14, **NMC's** Hospitalist Team conducted a review of readmission cases and identified several factors which put the patient at a high risk for readmission. These patients are given a low-cost Walmart prescription for their discharge medications.
Investment in IT & data analytics	**DPHs are investing in risk scoring & predictive tools, decision support, registries, dashboards and health alerts to track and care for this patient population.** • **KMC** created a readmission risk stratification tool that is given to all patients in the inpatient setting.

Project 2.2: Care Transitions: Integration of Post-Acute Care	
Key Themes	**DPH Examples**
	• **UCSD** implemented decision support within the EMR to require documentation of medication review when it is missing for in-person encounters within 30 days of an acute care discharge.
Workforce development	**Systems are ensuring workforce readiness to address care transitions by providing training on workflows, as well as health literacy and teach-back skills.** • **UCD** provided education to both nursing units and providers to address poor compliance with patients receiving a reconciled medication list at the time of discharge. • In Spring 2019, **RUHS** invited the Health Services Advisory Group to give training to inpatient providers on health literacy and the importance of teach back to ensure patients understand important discharge information.
Enhanced patient engagement	**Systems are focusing on improving the patient experience by: hiring dedicated staff to address patient satisfaction; identifying patient preferences through communication and awareness campaigns; and conducting patient rounding.** • In early 2019, **CCRMC** ramped up their patient preferences campaign called "We're Listening," where nurses routinely ask patients about their personal preferences and those preferences are documented on white boards in patient rooms for maximum visibility and awareness. **CCRMC** implemented a nurse teach-back module on medication management with a vendor that conducts automated post-discharge phone calls to patients. On each shift, nurses have also instituted a program call "Tell me Three," which focuses on asking patients three open-ended questions about medication instructions. This teach-back method reinforces patient health literacy, facilitates further discussion, improves adherence to post discharge instructions and enhances patient satisfaction. A related awareness campaign including posters, pins and laminated cards was also rolled out on all units. • In April 2019, **NMC** added questions related to medication and discharge planning to Leader-Patient rounding. At the end of DY14, NMC hired a Patient Experience Coordinator who will focus on resolution of patient complaints, improved patient communication and service recovery. • **RUHS** implemented hospital patient advocate rounding on newly admitted patients where the advocates welcome new patients, speak to them about their medications and adhering to the discharge plan, act as a partner in care decisions, and identify important preferences that will assist in a successful care transition. To strengthen patient and family involvement in understanding their care, RUHS has also implemented shift-to-shift bedside reporting where patients can ask questions about their treatment, hear about progress toward discharge goals, and share preferences utilizing white boards in their rooms. • During the second half of DY14, the **SJGH** transitions of care team implemented a new workflow to connect patients with more culturally appropriate care and meet patient needs based on preferred language. • **UCSF** enhanced patient discharge instructions to be more patient-centered, highlighting important contact information, follow-up appointments, and critical instructions. In DY14, UCSF's Care Transitions Outreach Program implemented a Virtual High-Risk Transitions program to engage vulnerable patients after hospitalization. • During DY14, **SMMC** implemented leader rounds to ensure patients' preferences were taken into consideration. • **UCI** is in the process of adding a post-discharge follow-up call system for all patients. • **UCLA** is now using email surveys to reach out to patients following discharge. • **VCMC** is utilizing Cipher to place automated calls to patients following discharge to address any potential concerns regarding discharge instructions, medications, or follow-up appointments.

Project 2.2: Care Transitions: Integration of Post-Acute Care	
Key Themes	**DPH Examples**
Strengthening &standardizing performance improvement	**Systems are making care transitions part of their standard work by developing working groups and integrating key program components into their existing operations.** • **CCRMC** quality educators began conducting rounds to assess the implementation of care transitions programs and identify unmet needs. • In August 2019, **RUHS** received an award from the National Research Corporation for the Most Improved Large Hospital for HCAHPS performance. • **SMMC** developed a care transitions program using grant funds in 2015. Although these grant funds have ended, SMMC has been able to absorb a majority of the key program components into existing processes. • **AHS** is developing an interdisciplinary readmissions working group, which will focus on improving care management. • **UCSD** engaged a multidisciplinary group of pharmacists, pharmacy technicians, physicians and nurses to standardize the medication reconciliation process across all clinic locations.
Challenges	• **Panel Management:** Difficulty ensuring continuity of care when patient population is assigned to a community provider. • Lack of improvement with shift to centralized call center • Lack of progress from patient experience workgroup in improving HCAHPS scores • **Staffing:** Understaffing due recent reduction in staff hospital-wide; Lack of staff to implement new programs. • **Documentation:** Lack of standardized documentation and reporting systems across hospitals within the health system.

Project 2.3 Complex Care Management for High Risk Medical Populations	
Key Themes	**DPH Examples**
Improved coordination & partnerships	**DPHs are engaging in collaborations with other waiver teams, outside hospitals/agencies and managed care plans to aid in the complex care management of high-risk patients.** • **CCRMC** collaborated with the Whole Person Care team for care coordination and to prevent redundancies, leveraging the EMR for shared documentation between team to improve care coordination. • **SJGH** coordinates with its local Medi-Cal managed care plans to connect high utilizers of acute care at outside healthcare facilities to primary care services and short-term outpatient case management. In addition, **SJGH** has made efforts to strengthen relationships with community hospitals to coordinate patients assigned to a SJCC primary care provider. • In DY14, **UCSF's** Care Support team expanded linkages to community-based resources by partnering with San Francisco Health Plan, other payor partners and community organizations. • **ARMC's** High Utilization Patient Care Outreach Program has evolved to include the SHAPE program, which provides behavioral health support for these patients.
Implementation of new processes & work flows	**Systems have implemented streamlined processes to improve the communication and management of high-risk patients. Best practice workflows are being integrated into clinical systems and to address complex social and medical needs.** • **AHS** has implemented standard protocols for performing, documenting and monitoring performance of post discharge phone calls within 72 hours. A tool was created to identify high-risk patients who are hospitalized and a work flow was implemented for case finding for Care Transitions and Complex Care programs. This streamlined process reduces the time previously spent case finding and documenting in numerous systems and allows for increased enrollment. • **CCRMC** collaborated on a countywide Food as Medicine project that assesses hunger vital signs for at-risk patients. • **NMC** 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. • **RUHS** instituted best practice algorithms, which include RN workflows, medication titration protocols and patient education for complex conditions. • **SFHN** Care Management Programs have adopted and are utilizing a universal care plan. SFHN is also working with the EPIC team to understand how the care plan format can be integrated into our enterprise-wide EHR. • **VCMC** designated a clinic Case Manager for each clinic and distributed their phone numbers to inpatient Case Managers so that there can be direct communication and a "warm hand-off" of complex patients.
Investment in IT & data analytics	**Systems are using dashboards, registries and predictive analytics to stratify and more effectively identify patients in need of robust complex care management.** • In DY15, **SJGH** will be implementing a robust care management tool through its EMR, which will support stratification of patients to readily identify patients at high risk and in need of complex care management. • **NMC's** is evaluating an integrated system-wide enterprise solution to more effectively meet the organizational population health management and information sharing needs. • **RUHS** is using EHR dashboard reports to enhance identification and track admissions for high-risk patients. Health Information Organization collaborations are extending throughout Riverside County. • **UCD** is using predictive analytics to efficiently identify and target high risk patients for case management.

Project 2.3 Complex Care Management for High Risk Medical Populations	
Key Themes	**DPH Examples**
Workforce development	**Systems are hiring additional staff; providing intensive training courses to promote sustainable practices; allowing clinical staff to work to the top of their license; and embedding nurses into complex care management programs to enhance communication with providers.** • **ARMC** reclassified existing Primary Care nurse positions RN Care Manager positions as part of the High Utilization Patient Care Outreach Program. One RNCM is embedded into each of the three Primary Care Clinics to capitalize on elbow-to-elbow communication with the primary care providers. • **UCSF** added 5 staff members (NP and SW) to the care support team, thereby doubling capacity to manage complex patients. An NP specializing in substance was also hired to help successfully transition patients to suboxone and prevent related hospitalizations. In DY14, team members began participation in a year-long intensive training course to build expertise on palliative care and symptom management for patients with serious illness. • **AHS** consolidated referral criteria and reviewed best practices for staff roles and staffing ratios in order to increase capacity to serve more patients. AHS also promoted a culture of continuous learning by providing teams with weekly trainings for subjects like motivational interviewing, trauma informed care and chronic disease management. • **UCD** successfully updated their Medication Reconciliation (Med Rec) policy, which allows for non-physician extenders (like nurses, pharmacists and pharmacy techs) to participate in the Med Rec process. • **SCVMC** added additional Complex Care Nurses and Community Workers to the team to manage complex patients, and high utilizers of multiple services.
Enhanced patient engagement	• **RUHS** care management teams implement screening for behavioral health and substance abuse disorders, provide proactive patient outreach, and conduct care planning involving the patient.
Strengthening & standardizing performance improvement	**Systems are scaling programs and interventions to reach additional patients.** • **CCRMC's** Complex Care Management pilot program, Care Connect, has transitioned to a social needs model with a total of three FTEs, including a community health worker, medical social worker, registered nurse, and alcohol and other dependencies social worker. CCRMC has expanded the reach of Care Connect to patients in East County on an as-needed basis. • **UCI** has scaled the ACO high risk patient management process to include additional beneficiaries in various risk groups/programs UCI participates in. • **SCVMC's** Vivitrol and/or Suboxone Therapy in the Emergency Department, Emergency Psychiatric Services, and Primary Care clinics resulted in a 30% reduction in ED utilization and readmission over the last 2 years. • **UCSD** has enhanced its care management program over the last few years through protocol development, an integrated care team model, customization of high-risk role-based workflows, and coordination between hospital transition teams and the high-risk program.
Challenges	• **Staffing:** Challenge to support program expansion to other geographic locations based on existing staffing structure. • **Lack of alignment between programs:** Differences in risk stratification and target populations for Health Homes, Whole Person Care and PRIME, which all have different risk stratification and target populations.