QIP PY2: System Level Activities

	QIP: Specialty Care Measure Highlights
AHS	**Identifying and addressing care gaps** • Ambulatory providers are notified of care gap alerts for patients with CAD not on antiplatelet or anticoagulant therapy and a best practice advisory is being developed in the new EHR (Epic). • All chart fall-outs are regularly reviewed by the heart failure workgroup to identify opportunities to improve coding and documentation or for coaching and feedback. **Developing the workforce and engaging teams** • A heart failure workgroup monitors performance, assesses gaps in current workflows and prescribing practices. • For each Specialty Care metric, AHS has created a leadership dyad between a physician lead and operational lead to lead performance activities related to their respective measure. **Improving data capture** • Continued focus on improving the standardized documentation and coding of exceptions to clinical guidelines, diagnoses, and discharge medications. **Strengthening and spreading standard workflows** • Developed anticoagulation guidelines to standardize anticoagulant use while optimizing patient outcomes and safety. **Educating providers and staff** • Conducting nurse-led review and provider feedback for patients not on optimal medical management. • To improve appropriate ordering and documentation of medications and exceptions, a standard documentation template was developed and disseminated to providers through presentations, posters, and pocket cards.
ARMC	**Improving data capture** • Instituted a new HIM program where provider privileges can be rescinded if documentation is not completed on time. **Developing the workforce and engaging teams** • Two FTEs were approved to help improve medication compliance and provider adherence to care protocols for all CHF, HF and other specialty care-related populations.
CCRMC	**Leveraging data** • CCRMC built several best practice alerts into the EHR for anticoagulant use, antiplatelet therapy, ACE inhibitor or ARB therapy, and beta blocker medication. **Improving data capture** • Starting this reporting year, providers also must document why a patient was not prescribed a medication if it was indicated in the best practice alert. Providers were educated on evidence-based practice and workflow impact through tips and examples.
KMC	**Improving access to care** • Added a service line for new pacemakers and defibrillators. **Expanding patient outreach and engagement** • To improve metric rates, KMC will implement bedside education for all heart failure and CAD patients. **Developing the workforce and engaging teams** • The Cardiology Department recently streamlined Atrial Fibrillation management by coordinating with clinical pharmacists to identify pathologies more quickly.

	QIP: Specialty Care Measure Highlights
LACDHS	**Strengthening and spreading standard workflows** • Revised formularies to include recommended beta blockers so that they are readily accessible for use by providers. • Encouraged use of heart failure Expected Practice guidelines, which is the most downloaded Expected Practice in the Clinical Care Library. **Improving access to care** • In the past year, LACDHS has reconfigured service lines to create dedicated Heart Failure clinics for the most severely ill patients. LACDHS is also improving the capability of primary care providers and their teams to manage the less complicated heart failure patients in the community-based clinic setting. **Improving data capture** • More systematically identifying patients with a contraindication to anti-thrombotic therapy. **Identifying and addressing care gaps** • EMR-based health maintenance tools flag when a patient with diabetes is not on an ACE or ARB. • Addition of discrete fields to capture ejection fraction to better report, identify and intervene on patients who are missing this measure. • LACDHS is running regular reports to assess when a patient is not receiving appropriate anti-platelet therapy, and is ensuring that they are linked and assessed by their primary care team for treatment.
NMC	**Strengthening and spreading standardized workflows** • Continued use of standard clinic processes, which includes including medication review and medication reconciliation by the MA and provider, to ensure that patients with a particular diagnosis are receiving appropriate therapy.
RUHS	**Strengthening and spreading standardized workflows** • Developed algorithms which align with standard RUHS best practices and incorporating evidence-based guidelines to bridge the gap between primary and specialty care. • Simplification of clinical pharmacist practices through incorporation of best practice recommendations into prescribing algorithm. **Identifying and addressing care gaps** • Developed registries for chronic diseases, including hypertensive diabetics with the goals to expand to heart failure and other CAD measures, allowing care teams to quickly identify patients with gaps in care and/or incorporate additional interventions.
SFHN	**Strengthening and spreading standardized workflows** • Prior efforts to improve cardiovascular health included registry development and creation of standard work and communication tools to identify and provide outreach to patients with CAD, HF and AFib/Aflutter to ensure they receive guideline-concordant medications. • Recent focus on spreading standard work to different healthcare teams, including inpatient cardiology, family medicine, outpatient cardiology and primary care teams. **Developing the workforce and engaging teams** • Restructuring of ambulatory cardiology services to manage patients with heart failure by relying on multidisciplinary team members such as pharmacists and nurse practitioners to provide in-person and telephone based clinical care.
SJGH	**Strengthening and spreading standardized workflows** • The transitions of care team is scheduling all necessary specialty and primary care appointments for patients leaving the ED or hospital.
SMMC	**Developing the workforce and engaging teams** • In PY2, SMMC added the role of Specialty Transformation Manager to help identify and address operational challenges in the specialty care area.

	QIP: Specialty Care Measure Highlights
UCD	**Leveraging data** • Continued expansion and usage of tools with the Epic Healthy Planet (population health module) including: leadership and provider level QIP specialty measure dashboards and non-compliant chase lists. **Expanding patient outreach and engagement** • Outreach using bulk communication to notify patients of care gaps or follow up appointments. • Pharmacist provide outreach to fall out cases to ensure appropriate education and documentation of medication use. **Improving data capture** • Contraindicated medications are listed on the problem list and marked as "long term" to improve data capture. **Training providers and staff** • Pharmacists are working with providers to ensure appropriate medication selection and/or determine alternatives if contraindicated.
UCI	**Aligning with other institutional initiatives** • UCI health has been a Get with the Guidelines (GWTG) Gold plus honor achievement award recipient annually since 2011 and was re-certified in October by the Joint Commission for its Advance HF Program in the ambulatory and inpatient care setting. **Strengthening and spreading standard workflows** • In the inpatient setting, order sets and discharge checklists were developed for AMI/ACS and HF using evidence-based guidelines. **Developing the workforce and engaging teams** • Hired an additional cardiology health coach for the cardiovascular practice team to assist with improving patient engagement. The coaches also assist the providers with health maintenance documentation updates. **Training providers and staff** • Lectures were provided to cardiology faculty and fellows on cardiovascular quality metrics and documentation, preventative cardiology, opportunities for improvement, and STEMI/NSTEMI guidelines.
UCLA	**Developing the workforce and engaging teams** • UCLA continues physician champion engagement on CAD measures and remains able to access the patient LVEF database due to cross collaboration efforts.
UCSD	**Improving data capture** • Focus on appropriate coding through extensive chart review. **Training providers and staff** • Training health care providers to appropriately document all patient diagnoses. **Strengthening and spreading standard workflows** • Develping best practice guidelines. **Developing the workforce and engaging teams** • The ambulatory cardiovascular team conducts frequent and ongoing meetings with primary care, cardiology, nurses, analyst, project management and clinical informatics specialist in QI. **Aligning with other institutional initiatives** *UCSD serves as the PI and/or is involved in the following collaborations:*

	QIP: Specialty Care Measure Highlights
	• **California Accountable Communities for Health Initiatives (CACHI)**, a project involving multiple community providers with the purpose of screening and preventing cardiovascular disease • **Prevent Obesity, Diabetes, Heart Disease and Stroke program**, which links multiple community providers to intervene with populations at high risk for hypertension and stroke • **San Diego Heart Attack Free Zone**, a project involving multiple community partners to decrease heart attacks and strokes using medication bundles, health coaching and home BP monitoring • **SE San Diego Cardiac Disparities Project**, which works with faith-based populations of color to implement policy systems and environmental change • **Be There San Diego Recommendations**, a program which works to develop shared guidelines for food security, physical activity, and nutrition to support cardiovascular health
UCSF	**Developing the workforce and engaging teams** • A Heart & Vascular Center (HVC) Quality and Value Council was developed to oversee cardiovascular measure tracking and improvement. • The Office of Population Health convened a multidisciplinary heart failure collaborative to develop a quality framework across UCSF for the treatment of heart failure. • Improvement specialists and analysts in the Department of Quality and Strategic Improvement Office, as well as a dedicated National Cardiovascular Data Registry analyst, supports HVC quality and safety projects at all operational levels. • In PY2, UCSF hired a Population Health Nurse Coordinator dedicated to reviewing all patient cases to assess appropriateness of medications, capture medication contraindications or exceptions, and communicate with providers. **Strengthening and spreading standard workflows** • Cardiology quality improvement efforts were expanded through the Marin Health Collaborative to the newly affiliated Marin cardiology practices.
VCMC	**Developing the workforce and engaging teams** • In PY2, VCMC aligned incentive bonus payments for cardiologists with the QIP specialty measures and provided education and support. **Leveraging data** • Developed a form in the EHR to streamline documentation for patients with Afib, with automatic calculation of the CHA2DS2-VASc score to facilitate medical decision making. • Expanded several clinical decision support tools for the cardiology measures within the EHR, such as creating an alert identifying patients with a CAD diagnosis and not on ACEi/ARB or beta blocker therapy.

	QIP: Resource Utilization Measure Highlights
AHS	**Educating providers and staff** • Ongoing education for providers to minimize extraneous and unnecessary testing and referrals. • Providers are given feedback when documented care is inconsistent with recommended guidelines. **Strengthening and spreading standard workflows** • Implemented a utilization management platform for outside referrals.

	QIP: Resource Utilization Measure Highlights
	• For safe prescribing practices, workflows and processes have been developed to enhance communication among providers throughout the system. This includes the co-management of patients with pharmacists, pain specialists and mental health specialists. Use of urine toxicology tests within primary care to assess for/identify misuse have been adopted. **Improving access to care** • AHS recently received grant funding to increase medication assisted treatment (MAT) in primary care patients with opioid use disorder (OUD) at Highland and Eastmont Wellness. **Developing the workforce and engaging teams** • For each Resource Utilization metric, AHS has created a leadership dyad between a physician lead and operational lead to lead performance activities related to their respective measure. • At Highland Hospital, the primary care clinic has an Opioid Review Committee, which manages the opioid refill process and ensures an active CMUA is present before approving refills.
ARMC	**Strengthening and spreading standard workflows** • Protocols were updated in the ER and Primary care, which has reduced the number of unnecessary procedures and costs. **Leveraging data** • Set up electronic alerts to validate ordering of higher cost procedures.
CCRMC	**Leveraging data** • Built an alert to identify dually prescribed patients and remind providers during the patient visit that dual providing is not in alignment with recommended practice. **Strengthening and spreading standard workflows** • Re-evaluating drug formularies, co-prescribing practices and automatic prescription refills to ensure inclusiveness in care for all our populations and reduce unnecessary or redundant prescriptions or prescribing practices that are not aligned with evidence-based care. • Worked with CCHP and PRIME project 2.6 teams to limit dually prescribed opioids and benzodiazepines to patients with a cancer diagnosis only. • CCRMC is identifying and empowering project leads to draw on their expertise to develop and implement criteria for high-risk surgeries for appropriate imaging usage.
KMC	**Developing the workforce and engaging teams** • During this reporting period KMC consolidated their inpatient and outpatient quality teams and realigned them around three key focus areas: data integrity and reporting, process improvement, and regulatory compliance. As part of this realignment they are implementing formalized process improvement and data integrity methodologies. **Educating providers and staff** • KMC convened a process improvement group with staff who educate physicians, clinical pharmacists and clinic staff regarding the requirements of the cardiac stress imaging measure. **Aligning with other institutional initiatives** • Many of the process and lessons learned from PRIME project 3.2 relating to imaging utilization in the emergency department setting are being utilized for QIP.
LACDHS	**Strengthening and spreading standard workflows**

	QIP: Resource Utilization Measure Highlights
	• LACDHS is re-evaluating its pre-operative testing criteria for a number of low risk surgeries and has engaged the Non-Cancer Pain and Addiction Medicine workgroups. • LACDHS has developed Expected Practices to support non-opioid approaches to pain management. LACDHS is also more actively involving pain expertise (via eConsultation) before a referral to an out of network Pain Management clinic is undertaken. There are 3 eConsult portals aimed at educating and supporting providers who are managing patients on long-term opioids. • LACDHS has expanded its MAT program, and has assisted 200 providers in getting "x-waivers." There have been month-on-month increases in patients on MAT for the past year.
NMC	**Strengthening and spreading standard workflows** • For decreasing unplanned returns to the OR, the surgical department has implemented and monitors compliance with AORN's best-practices for perioperative services and Joint Commission standards. • For medication management, quarterly reports are reviewed with a list of all prescribed medications by provider. If a patient is on benzodiazepines and opioids, the Medical Director verifies that the patient is current on their urine toxicology testing, their pain agreement and provider documentation of PDMP check. Providers receive a grade on their prescribing practices during their annual review. If the provider has patients on benzodiazepines and opioids, they are asked to develop an action plan to stop providing dual therapy. **Developing the workforce and engaging teams** • The Perioperative Services Director and physician leaders are members of the organization's multidisciplinary Surgical Improvement Committee. Process improvement project reports, results of audits and NSQIP reports are presented and strategies for improvement are discussed. The Perioperative Services Director in conjunction with the physician Surgery Department Service Director, is responsible for implementing system and/or process changes to address identified issues.
RUHS	**Improving data capture** • During PY2, a transition was made from non-clinical quality abstractors to experienced clinical RN staff, reducing inaccurate coding and allowing for proper identification of issues. **Aligning with other institutional initiatives** • RUHS continues to plan for and put in place the resources needed to attain Level 1 trauma verification to meet the growing demand for services at its Moreno Valley-based Medical Center. RUHS is actively preparing for Level 1 ACS verification, scheduled for May of 2020. **Identifying and addressing care gaps** • Revamped the PIQI process to have weekly PI meetings to discuss cases and identify opportunities to improve care. **Improving access to care** • RUHS opened five new beds in its emergency department and trauma center, recruited 5 board certified fully trained trauma/critical care/acute care surgery faculty, opened a dedicated Surgical ICU to improve care to critically injured patients, and developed the active injury prevention program. **Educating providers and staff** • Conducted its annual trauma conference and offering of ATLS/ATCN courses. Additionally, RUHS developed a research center, which is being spearheaded by RUHS' chief surgeon.
SFHN	**Educating providers and staff** • Cardiologists provide technical expertise via eConsult and in person consultations to evaluate the necessity of cardiac stress testing when needed. They also educate primary care physicians in pre-operative anesthesia clinic regarding the appropriate use of stress testing.

	QIP: Resource Utilization Measure Highlights
	Improving data capture • In October 2018, SFHN made modifications to the opioid safety and chronic pain registry to flag patients on benzodiazepines and patients on controlled medications without a documented CURES review in the last four months. Primary care leveraged local clinic analysts and chronic pain champions to help monitor opioid safety metric rates and provide reports to the individual clinic providers. After registry enhancements, individual providers reduced their co-prescription of opioids and benzodiazepines.
SMMC	**Aligning with other institutional initiatives** • Through PRIME work, SMMC engaged with organizational leadership and developed a process to monitor appropriate use of imaging services. Participating in QIP has allowed for the expansion of that engagement to include ancillary departments. **Improving data capture** • During PY2, SMMC analyzed the current state of the emergency department, radiology, and inpatient departments and identified ways to better capture clinical information that was otherwise paper-based or only in narrative form. • Through a partnership with emergency department leadership, the PulseCheck emergency department application was enhanced to allow for structured data entry and to facilitate reporting outputs. Staff and providers were educated on the metric details and the importance of standardizing their documentation. • Collaborated with the improvement nurse and reporting team to better understand and interpret HPSM prescription claims data, which has resulted in improved identification of prescriptions meeting measure specifications. **Workforce development** • SMMC has incorporated a clinical improvement nurse whose role has been critical in understanding the challenges in documentation entry, capture of specific information, and identifying opportunities for improvement.
UCD	**Development of algorithms and clinical guidelines** • UCD created the PECARN Pediatric Head Injury/Trauma Algorithm in the EHR, which allows providers to determine which pediatric patients they can safely discharge without obtaining a head CT. **Improving data capture** • UCDH emergency department has worked with the IT/Epic team to create a structured indication tool to accurately capture diagnoses and serve as a tool to remind physicians that imaging should only be ordered when clinically indicated by evidence-based practices. **Developing the workforce and engaging teams** • To reduce re-operations, UCDH has put together an SSI workforce, which utilizes surgical checklists and reinforces timeout processes. • UCDH has created a new transitions of care department which has focused on readmissions, moving all prescriptions at discharge to in-house, follow-up calls after discharge, and continued case management.
UCI	**Leveraging data** • UCI has implemented a number of clinical decision support tools in the EMR which are focused on alerting providers of patients taking opioids, including concomitant benzodiazepines. These tools provide a prompt to check the CURES database, order a recurring annual opioid agreement and urine drug screen. • The EMR also has an alert for the provider to prescribe naloxone when the patient is high risk for overdose. **Strengthening and spreading standard workflows**

	QIP: Resource Utilization Measure Highlights
	• To improve the appropriate ordering of CT scans for patient with minor head injury, UCI has implemented indications for ordering providers in the Ambulatory and Emergency-Department settings, helping to raise awareness for appropriate ordering. • To support continued improvement efforts, UCI has adopted and is implementing Just Culture and TeamSTEPPS programs to open and improve communication across the organization.
UCLA	**Leveraging data** • In PY2 UCLA worked extensively with Medi-Cal Managed Care Health Plans, to implement a Safe File Transfer Protocol exchange with Molina and LA Care in order to integrate claims, lab and pharmacy data into QIP performance data. This new process will help the Population Health and primary care teams monitor use of opioids and benzodiazepines. • UCLA collaborated with other UC systems to share programming for exclusion of multi-system trauma patients. • Use of claims data from the Medi-Cal Managed Care Health Plans made a significant improvement in data performance. **Developing the workforce and engaging teams** • UCLA has a robust pain management steering committee in inpatient hospitals who are responsible for offering non-prescription pain relief options, proactively identifying high risk opioid groups, and conducting pre-operative pain assessments.
UCSD	**Strengthening and spreading standard workflows** • Significant efforts are being made around SSI prevention strategies in order to reduce unplanned returns to the OR. These include specific SSI prevention activities, ERAS interventions and monitoring protocols for high risk procedures (e.g. colorectal surgery) with a feedback loop mechanism to the front-line for compliance improvement. • Current QI efforts have sought to unify existing evidence of published criteria that could be applied in clinical decision support through an integrated tool within the EHR. As part of this, UCSD has been collaborating with UC Irvine in the Clinical Decision Support Medicalis Project for appropriate imaging utilization with a focus on head and neck imaging. **Developing the workforce and engaging teams** • UCSDH has a robust multidisciplinary Ambulatory Cardiology Quality Committee that tracks performance using Tableau for cardiac stress imaging. **Identifying and addressing care gaps** • An ambulatory opioid registry is being used to better identify patients with chronic opioid use who have care gaps related to urine testing, pain contract, CURES documentation, and Narcan. Decision support is enabled for providers treating patients at high risk for benzodiazepines and for the co-administration of opioids and benzodiazepines.
UCSF	**Aligning with other institutional initiatives** • The UCSF Center for Healthcare Value (CHV) sponsors the Caring Wisely Program, an organized process for engaging and supporting frontline clinicians in efforts to remove unnecessary costs from healthcare delivery systems and improve the quality of care delivered. Past project results show notable decreases for target groups in blood transfusions, nebulizer treatments, operating room supply costs, postoperative opiate use, length of stay for surgical patients, and overuse of antibiotics. **Strengthening and spreading standard workflows** • UCSF has standardized pre-surgical testing throughout the health system through its Prepare clinics. All surgical patients undergo a comprehensive pre-surgical evaluation. Patients are risk-stratified for appropriate pre-surgical testing using evidence-based guidelines. **Developing the workforce and engaging teams**

	QIP: Resource Utilization Measure Highlights
	• In PY2, UCSF launched an interdisciplinary workgroup to evaluate clinical guidelines for imaging, which included representation from internal medicine, emergency medicine, radiology and informatics/clinics systems. The group also consulted with teams at other UC sites to share and adopt best practices around imaging guidelines and integration in the EHR.
VCMC	**Educating providers and staff** • After a comprehensive list of low-risk surgical procedures was developed for the "Preoperative Evaluation in Low Risk Surgery Patients" measure, RUHS began provider education regarding appropriate resource utilization for tests only indicated in high-risk cases. **Leveraging data** • In PY2, VCMC worked in small groups with IT to determine how EHR enhancements could help capture timing of injury, indications for CT, and exclusions from the denominator. There was also an increased focus on the education of ED providers on proper documentation of these particular elements. **Identifying and addressing care gaps** • Using manual chart audits to identify correlating risk factors that can be used to proactively identify patients at risk for reoperation. In addition, the Surgery Team sends the Quality Team real-time data about patients with unplanned ROR so these can be reviewed concurrently.

	QIP: Primary Care Measure Highlights
AHS	**Strengthening and spreading standard workflows** • Standardization of the discharge summary to facilitate post discharge medication reconciliation and post discharge follow-up. To improve the percentage of patients who received a phone call within 72 hours and attended a clinic visit within 7 days of discharge, AHS convened a group of stakeholders to standardize tools and processes for case finding. • Workflows were developed for chronic care team medical assistants and community health workers to call patients and schedule an appointment. Reports were refined to help identify patients with an upcoming primary care appointment as well to conduct "in-reach." • Development of provider prescribing guides with specific formulary options to optimize medication fill/refill practices for diabetic and asthma patients. • Implementation of a nurse-led immunization protocol for pediatric patients. **Identifying and addressing care gaps** • The following activities are done to ensure vaccinations are completed in a timely fashion: immunizations records from CAIR are reviewed during the daily morning huddle and flagged as needing a vaccine. In the event of a no-show, patients are notified via letter of their care gap. • Care gap reports were created to identify patients in need of an eye exam. **Leveraging data** • AHS is building health maintenance advisory and best practice alert notifications for immunizations into their EHR, which is expected to launch in PY3. • The ambulatory quality dashboard has been modified to align with recent blood pressure guidelines and the new HEDIS blood pressure targets. • Implemented dashboards to monitor team Care Transitions and Complex Care team's capacity, individual staffing ratios, telephone calls and post discharge appointments. **Developing the workforce and engaging teams**

	• AHS established a multidisciplinary workgroup to identify the following interventions: (1) more robust patient in-reach and outreach, (2) partnership with health plans to capture data related to services received outside AHS, and (3) scrubbing of internal data specifically for patients who received a normal eye exam in the 13-24-month window. • The primary care site chronic care teams (multidisciplinary teams of a clinical pharmacist, nurse, and dietician) recently added an MA to increase outreach efforts. • For each primary care metric, AHS has created a leadership dyad between a physician lead and operational lead. In addition, AHS has two Quality and Performance Improvement Managers (to assist metric leads and build QI capacity among the wellness centers). **Improving access to care** • AHS has expanded the Complex Care Management teams to three clinic sites. **Aligning with other institutional initiatives** • Continues to leverage the long-standing PHASE initiative, which funds efforts to improve glycemic and blood pressure control in patients with DM and HTN.
ARMC	**Strengthening and spreading standard workflows** • ARMC is working with IEHP to streamline the eConsult/eReferral system to better track referrals and consults as well as to create a quicker turnaround time for patients to see specialty providers and/or procedures related to DM eye care. • Behavioral health integration experts are providing coaching for clinical improvement and supporting infrastructure development of an in-house behavioral health department within Primary Care Clinics that will focus on clients with multiple co-morbidities related to DM. **Developing the workforce and engaging teams** • ARMC hired credentialed behavioral health staff (clinical social workers) to work with primary providers to evaluate treatment plans and coordinate behavioral health care in one setting.
KMC	**Expanding patient outreach and engagement** • A clinical team dedicated to effectively managing the health care needs of the diabetic patients assigned to KMC reaches out to the diabetic patients frequently throughout the program year to schedule HbA1c labs and all patients with a high HbA1c are referred to the diabetic clinical pharmacy clinic to help manage their diabetes. The clinic is run by pharmacists who help the patient by scheduling lab checks, educating on self-management, reviewing medications, and encouraging them to attend the free diabetic events held monthly. • A clinical team dedicated to effectively managing the health care needs of the children and adolescents reaches out to the parents of these children frequently throughout the program year to schedule primary care appointments. Any child who is not up-to-date with their immunizations is scheduled for a primary care appointment. • The Acute Care Transitions team dedicated to patients discharged from Kern Medical Center calls each high-risk beneficiary within 72 hours of discharge. • Teams provide phone outreach to individuals who are non-compliant with metric specifications to schedule appointments. **Improving access to care** • To help adolescents receive immunizations on time, KMC has extended clinic hours on Tuesday and Thursday till 8:00 pm and are now open on Saturdays. The clinical team also collaborates with parents to allow for multiple children from the same family to be seen during the same visit. • KHS has provided additional grant resources for the establishment of a diabetes-centered specialty care clinic, which will allow for enhanced care coordination and population health management.
LACDHS	**Strengthening and spreading standard workflows**

	• Created and deployed 9 Expected Practice (EP) documents, which advise providers on a large range of diabetes-related patient care areas. Together, these EPs have been downloaded more than 10,000 times by DHS-network providers. • Addition of new functionality to the population health platform that allows individual providers and clinic leaders to view how patients are meeting glycemic targets and trends in real time. • Efforts to improve the transition for patients from hospital to primary care medical home include notifying primary care providers when their patient is admitted and delivering a follow up primary care appointment soon after discharge. • LACDHS continues to offer its TeleRetinal Diabetetic Retinopathy Screening program, which was deployed 6 years ago and has helped improve rates of screening. **Leveraging data** • DHS built a bi-directional interface with CAIR and the EMR, which will replace manual chart abstraction during the upcoming program year. • Tools in the EHR flag vaccine needs for patients. A new EHR module was also deployed that allows for standardized recording of vaccines by NDC number, eliminating a process that varied between sites. **Interdisciplinary teams and workgroups** • Since QIP began, DHS has named measure specific leads who have convened system-wide workgroups dedicated to improving practices and creating new tools to improve performance in each of the Primary Care Domain measures. **Educating providers and staff** • At the largest primary care sites, LACDHS has deployed practice coaches who provide elbow support to providers who may need reminders regarding patients who need intervention. The coaches also disseminate up-to-date provider and patient level data to the clinics to help prioritize and focus efforts.
NMC	**Aligning with other institutional initiatives** • MCHD clinics and NMG are pursuing NCQA PCMH certification in 2019 and 2020. • Received grants from Community Foundation for Monterey County and Pajaro Valley Health Trust to continue offering the proven 5 Steps to Prevent Diabetes program for an 8th year. **Educating providers and staff** • Ongoing management of provider immunization practices. If a provider begins offering alternative immunization schedules, the medical director is alerted then coaches the provider. **Developing the workforce and engaging teams** • A new position was hired, a dedicated Quality Improvement analyst/Medical Assistant (MA), to focus on process improvement and outreach to patients. **Leveraging data** • NMC's SSRS registry dashboard tool is used to identify diabetic patients in need of HgbA1c testing, and allows clinic workflows to close gaps in care with focused patient follow-up. **Strengthening and spreading standard workflows** • In redesigning the care processes, vaccination is now provided as the default and no vaccination as the exception. Children are vaccinated at all visits, even if it is not a well-child check visit. Clinics use CAIR with a bi-directional interface to the Epic EHR. Providers do not provide written exceptions to opt out of immunizations for school enrollment. MAs are responsible for vaccination processes. Weekly reports are scrubbed and pre-visit planning identifies every child needing an immunization. • In addition to using point-of care A1c testing, NMG is incorporating diabetic foot exams and wellness care into diabetic patient follow-up visits.

	• Utilization of new clinic workflows and corresponding documentation in MEDITECH, which are incorporated into daily staff routines to drive pre-visit planning and gaps in care closure. • Implemented a new process in January 2019 where a Care Navigator is responsible for making follow-up appointments for Med/Surg medical and family medicine patients prior to discharge. **Improving data capture** • During PY2, the team analyzed the case fall-outs and worked with primary care providers to make sure the med rec was documented correctly during the post-discharge primary care visit. **Expanding patient outreach and engagement** • Implementation of new processes which have led to an increase in utilization of non-emergent care, including a new patient orientation letter for outreach and an increase in preventative in-reach.
RUHS	**Aligning with other institutional initiatives** • The IEHP Health Homes Program collaborated to support complex patients' diabetic needs. Health coaches teamed with nutritionists for motivational support touches. Providers continue to use pocket card algorithms with formularies for diabetes medication initiation and titration. **Strengthening and spreading standard workflows** • The IEHP Health Homes Project collaborated with the complex care teams using Manifest MedEx Admit-Discharge-Transfer (ADT) notifications to schedule patients for provider visits to minimize their post discharge needs. RNs reviewed the EPIC daily discharge of patients with the salient diagnosis groups and also called in patients with diabetes or high IEHP claims risk scores for 7-day return. • Efforts are underway to re-design and standardize clinic workflow from pre-visit through discharge to improve care delivery. The first phase of re-design began this year with a pre-visit chart prep pilot in 2 clinics, which uses specially designed smart phrase visit notes and patient phone calls to confirm information, begin med reconciliation and to provide care reminders. The pilot has been successful in providing a more compete medical record for the provider and a more efficient visit and will be implemented at all clinics at the beginning of 2020. • Currently, retinal photos are transmitted to an EyePACS team, consisting of four credentialed Ophthalmologists contracted to read retinal photos and send back results to the primary team. A workflow re-design project is being piloted at one clinic site in which patients are sent for same-day retinal photos after their primary-care appointments. **Expanding patient outreach and engagement** • A clinic outreach dashboard in EPIC is utilized for outreach calls made to patients who are due for their immunizations. RUHS also actively pursues missed appointments with reminder calls made by the staff. This outreach intervention has proved to have more effect in patient response than auto-dialer calls. **Improving access to care** • During PY2, one clinic made available weekday walk-in appointments for immunizations and two clinics added after hours clinic appointments from Wednesday-Friday and Saturday appointments.
SFHN	**Identifying and addressing care gaps** • The immunization coordinator reviewed missed vaccination opportunities in pediatric primary care for follow up. **Developing the workforce and engaging teams** • SFHN also convenes a monthly multidisciplinary meeting aimed at bringing diverse providers together including primary care, pharmacy, and nutrition and endocrinology to encourage collaboration and explore team-based care for diabetes.

	• Addressed adolescent immunizations the following ways: (1) leveraged monthly pediatric QI workgroup as a platform for communication to discuss performance and quality; (2) Used training in lean management strategies to create an A3 to identify root causes and barriers to on-time completion of adolescent immunizations. **Improving data capture** • In PY2, improvement work centered on post-discharge telephone encounter documentation, and workflows were evaluated and adjusted to meet specification documentation protocols. Frontline staff that conduct and schedule post-discharge visits and calls were trained to the new standard work via webinars. **Strengthening and spreading standard workflows** • SFHN worked on standardizing care coordination with primary care to improve 7-day post discharge follow-up and panel management outreach. SFHN piloted a centralized call center outreach for post discharge calls at one of our clinics, where post-discharge phone calls increased from 12% to 25%. • Conducted a PDSA in collaboration with the SF Health Plan (SFHP) to test whether a centralized approach to outreach would help improve adolescent immunization rates across primary care clinics that serve pediatric patients. Outreach lists were generated and distributed to clinics with clinic-specific goals for outreaching to patients who were due for one or more vaccines. Clinics that met their goals over the PDSA measurement period were given an incentive from SFHP. **Improving access to care** • SFHN is extending the reach of diabetic retinopathy (DR) screening with a mobile Eye Van equipped with a camera and technician to primary care clinics throughout the city on a rotating schedule. DR screening is also available onsite at two primary care clinics and walk-in DR screens are available at optometry/ophthalmology clinic for three campus clinics.
SJGH	**Strengthening and spreading standard workflows** • During the second half of PY2, uncontrolled blood pressure was added to the pre-visit planning roster in order to track and provide timely intervention. **Educating providers and staff** • Implemented focused trainings at all clinic sites on proper blood pressure taking technique and documentation. **Leveraging data** • The addition of two new Optovue Vivicon Robotic Retinal Cameras at SJCC during PY2 facilitated effective diagnosis and management of diabetic retinopathy. **Aligning with other institutional initiatives** • SJGH is in the third and final year of its PHASE grant program, which is administered by the quality improvement department. **Developing the workforce and engaging teams** • A grant from the Center for Care Innovations supported the piloting of medical scribes in SJGH/SJCC s primary clinics during 2018-2019. With three ambulatory scribes, the project demonstrated improvements in care provided, productivity, and provider and patient satisfaction. Due to the positive outcomes of this initiative, SJGH is expanding scribe services at its FQHC sites in early 2020.
SMMC	**Aligning with other institutional initiatives** • SMMC uses PHASE grant funding to support promotion of three medications, along with lifestyle changes, for people with existing heart disease and those at greatest risk for developing it, including diabetics age 55 years and older. The PHASE grant funds have supported the ongoing training of our staff in Health Coaching principles, which to date surpasses 100 staff throughout the organization. **Developing the workforce and engaging teams**

	• In PY2, SMMC continues to strengthen its care team structure by defining care team member roles, developing protocols allowing each care team member to work at the top of their license and supporting daily operations through the implementation of standard work to further drive improved outcomes. Additionally, SMMC is developing a leader support model where the QIP Primary Care Metrics are monitored and reported on daily.
UCD	**Developing the workforce and engaging teams** • Hired a new endocrinologist to lead the Inpatient Glycemic Team and facilitate work with the Multidisciplinary Diabetes Care Committee to further develop policies, education and raise awareness of diabetes stewardship across the health system. **Leveraging data** • Developed and rolled out a Best Practice Advisory Alert in Epic, which prompts both primary care and specialty care clinicians to complete the med rec at every encounter after the patient has been discharged. • One retina camera for diabetic screening has been added to the ACC family medicine clinic at UCDH with funding approved to add three more. **Improving access to care** • UCDH has started a partnership with a county FQHC to see assigned MMC patients for primary care to improve access to care. • UCDH continues to have same-day access for all patients, and children are made a priority. Templates have blocked time every day to account for same day appointments. **Expanding patient outreach and engagement** • Cipher Health use has continued for follow-up calls. **Strengthening and spreading standard workflows** • Created standardized call documentation in EMR, which helps clinics identify post-discharge issues such as transportation, medication cost, incomplete referral, DME equipment, etc.
UCI	**Strengthening and spreading standard workflows** • UCI has a standardized protocol for both support staff and providers to check and address high blood pressures. Patients with repeatedly elevated blood pressures are also referred to chronic care management (PharmD) located in the clinic. • All patients who are identified as non-compliant with AMR are reviewed by a medical student or nurse practitioner for accuracy of diagnosis and management. • The readmission taskforce has partnered with ambulatory to develop a workflow that supports an internal follow up appointment to the patient's PCP in < 7 days. The workflow is currently in the process of being vetted before roll out. **Increasing access to care** • UCI has expanded discharge clinic access to provide more post-discharge appointments throughout the entire week, including Saturdays, rather than just one clinic per week. UCI updated the med reconciliation policy and procedure to provide more clarity around the roles and responsibilities of the reconciling provider versus the prescribing provider, which has increased compliance.
UCLA	**Aligning with other institutional initiatives** • Through collaboration with the Office of Population Health and Accountable Care (OPHAC), UCLA identified Comprehensive Diabetes Care as a FY20 care gap priority. OPHAC and the Department of Medicine will work together to provide recommendations and synergize efforts with the Diabetes design team to improve measure performance in PY3. **Improving access to care** • Through the design team and collaboration with UCLA Ophthalmology, UCLA is working to expand retinal screenings in primary care clinics. **Developing the workforce and engaging teams**

	• Working to improve performance through a newly reconstructed diabetes design team, which includes diabetic educators and ambulatory care pharmacists. This team reviewed the current state of diabetes management in the primary care setting and identified projects that could be broadly implemented across the primary care practice group. • A workgroup has been established with the Pediatrics and Family Medicine clinical champions and project management support from Quality to ensure children and adolescents receive appropriate access to PCP care and immunizations in PY3.
UCSD	**Expanding patient outreach and engagement** • Existing diabetic protocols help to improve patient engagement and completion of screening as well as outreach to diabetics with poor control to receive diabetes education, intensive pharmacist support and endocrinology eConsults. Infrastructure includes EMR templates, care navigators, and diabetic retinal exam EMR integration. **Strengthening and spreading standard workflows** • UCSD has identified diabetic bundles and expects to begin implementing these workflows in the upcoming reporting year. **Identifying and addressing care gaps** • Through chart review, UCSD have identified that the refill process is an opportunity for future quality intervention in asthma care. **Improving access to care** • Access for youth has been expanded through the new Via Tazon facility.
UCSF	**Developing the workforce and engaging teams** • In 2019, UCSF hired a Population Health Nurse Coordinator, a Healthcare Navigator and a Practice Coordinator dedicated to QI projects aligned with the QIP primary care measures.
UC-Wide	**Collaboration and partnerships** • There is a UC wide primary care collaborative with primary care leadership and front-line staff from all 5 UC campuses that meets bi-annually to share to share best practices and tackle challenges. Current initiatives are focusing on behavioral health, care gap closure, and strategies for addressing health disparities. This forum allows for sharing of innovations and standardization of practice across the 5 UC's.
VCMC	**Leveraging data** • VCMC developed a clinical decision support tool in the EHR for controller medications for patients who meet criteria for persistent asthma. The EHR "alert" provides real-time feedback regarding which patients would benefit from medication that prevents exacerbations and allows physicians to order the appropriate controller medications directly from the alert box, thereby minimizing additional steps in the clinical workflow. • VCMC continues to use clinical decision support tools to better track patients recently discharged from the hospital. The EHR "alert" informs providers when an assigned patient is hospitalized and reminds providers to reconcile medications within 30 days after discharge. • Enhanced retinal screening services by installing new cameras at all primary care clinics and drafting a clinical guideline policy. This has allowed for retinal screening at primary care visits. **Identifying and addressing care gaps** • Using data from the EHR to identify care gaps, clinic staff is able to conduct "same-day retinals." • Developed clinic reports to identify patients who had not been seen in the appropriate time period. Light duty and other staff were enlisted to support and assist in outreach efforts. • Trained clinic staff to import CAIR immunization records into the EHR, which allows staff to reconcile internal and external vaccination records, review the complete vaccine history, and identify gaps in the vaccine schedule.

	QIP: Inpatient Care Measure Highlights
AHS	**Addressing gaps in care** • Ongoing chart reviews and reports are generated to address potential fall outs for the appropriate administration of prophylactic antibiotics and VTE occurrences. • Concurrent review by Clinical Nurse Supervisors and the Stroke Coordinator for all patients discharged on antithrombotic therapy. **Strengthening and spreading standard workflows** • Automatic consultation for patients with MSSA bacteremia to ensure optimized, evidence-based treatment plans. • Development of standard order sets and protocols, including: Perioperative order sets to ensure the appropriate administration of VTE prophylaxis; Development of a standard Central Line Insertion Protocol (CLIP) template by an interdisciplinary workgroup; Development of stroke order set with embedded formulary for appropriate antithrombotic selection.
ARMC	**Strengthening and spreading standard workflows** • Implemented changes to infection control protocols including the hand hygiene protocol and pre-operative nursing protocols requiring the use of CHG wipes prior to surgery. The changes to the preop protocols are now included on the pre-op check list and part of the patient education during the clinic visit.
CCRMC	**Strengthening and spreading standard workflows** • Reviewed and updated policies and procedures based on best practices to reduce risk of infections by offering an alternative to central line use and expanding the use of peripheral and midlines as an alternative.
KMC	**Leveraging data** • KMC purchased vein finder devices for all nursing areas and educated on the mandatory use of the vein finder for peripheral vein insertions. **Strengthening and spreading standard workflows** • Built order sets to include antithrombotic therapy medications. • Instituted Enhanced Recovery After Surgery (ERAS) best practice bundles to prevent surgical site infections in patients having colon surgery and cesarean sections. • Continued to use a separate Vascular Access service, which has specially trained nurses to track and provide care for every CVC in the hospital. • Incorporated the discussion and evaluation of CVC by nurses and providers in bedside rounding. **Improving access to care** • Partnered with KHS to create two PCMH clinics to better meet the treatment needs of high-utilizing patients, with an emphasis on promoting health management through education and chronic disease management to avoid emergency room visits and inpatient stays. **Aligning with other institutional initiatives** • Maintained Joint Commission's Advanced Certification for Primary Stroke Centers during PY2. • Participated in the Collaborative Alliance for Nursing Outcomes (CALNOC), which includes collaborative data sharing for infection control. Participated in an ICU infection control collaborative through the Hospital Quality Institute.
LACDHS	**Strengthening and spreading standard workflows** • Redesign of the CLIP procedure form embedded in the EHR to clarify and document best practices for maximal sterile technique. Added antithrombotic therapy to the standard order sets for post-stroke care. **Educating providers and staff**

	• The antibiotic stewardship team monitors antibiotic use and flags areas where either a specific provider or an entire specialty has practice patterns apart from the standard. • Provide coaching/support to providers who fall out of compliance to help them review the evidence and assess their decisions. In the rare cases where the provider objects to the treatment recommendations, the Antibiotic Stewardship group can review the case to determine if optimal care was provided.
NMC	**Strengthening and spreading standard workflows** • Natividad's surgical department has incorporated VTE prophylaxis into the pre-op surgical checklist and a sequential compression device is available for use in each operating room, helping to standardize nursing staff processes. **Improving data capture** • In PY2, Discrete fields were added for all CVC insertion elements into the EHR workflow for Operating Room and Interventional Radiology in order to improve data capture. • Report logic was also updated in order to ensure accurate inclusion of all values.
RUHS	**Strengthening and spreading standard workflows** • Implementation of the Stroke Core, Quality & Achievement Checklist to assist with Stroke measure compliance. Standardized discharge forms have also been created which includes the evidence-based guideline recommendation to discharge patients. • Reminder messages are left in the chart for physician to notify the Stroke Team for all patients that are discharging with a stroke diagnosis • Developed VTE order sets, which contains algorithms to help physicians assign patients to different risk categories to receive guidance on prophylaxis orders most appropriate for the patient. • References manuals containing evidence-based practice guidelines are located in every unit that cares for stroke patients. • Established institutional guidelines for antimicrobial prophylaxis for surgery addressing use of first- and second-generation cephalosporins per National consensus guidelines. **Developing the workforce and engaging teams** • The RUHS-Medical Center Infection Prevention and Control (IPC) department expanded a multidisciplinary team of key stakeholders to implement processes to reduce and eliminate surgical site infections. A root cause analysis on possible causes of surgical site infections and existing care gap was conducted, findings were shared with all surgeons, anesthesiologists, and OR nurses, and PDSA cycles were conducted evaluate quality improvement efforts that would correct the deficits. • The Hospital Performance Improvement Committee met regularly during PY2 to focus on the following performance improvement projects: Hospital Acquired Pressure Ulcer Reduction, Central Line Associated Blood Stream Infection Reduction, Catheter Associated Urinary Tract Infection Reduction, Restraints, and Nurse Communication. • Data presentations to improve SSI rate were provided during the Infection Prevention and Control quarterly meeting and the OR committee meeting. **Leveraging data** • RUHS Procedure carts have been built and used in the ED and ICU care environments to ensure efficient and easy access to all the necessary supplies. **Expanding patient outreach and engagement** • Implementation of the daily rounding on stroke patients, utilizing the Stroke Rounding Tool by the Stroke Program Coordinator in PY2.
SFHN	**Leveraging data** • Multiple planning stakeholder sessions were held in PY2 to ensure QIP metrics were considered in the new EHR workflow, which includes: updating provider documentation, nursing flowsheets, and order sets to support improvement efforts. **Aligning with other institutional initiatives**

	• ZSFG has integrated its work in QIP within the organization's True North Scorecard, which tracks organization's strategic goals and metrics and an A3 has been developed to guide the work. • ZSFG is also working to integrate QIP work within the rollout of the Daily Management System across all departments, which aims to promote problem solving and alignment among front line staff, supervisors, managers, directors and executives through Status Sheets, Daily Huddles, PDSAs, Standard Work and Unit Leadership teams.
SJGH	**Educating providers and staff** • During PY2, the GME department facilitated monthly GME research committees that brought residents, attendings, and care teams together to focus on improving inpatient care through didactic sessions and clinical case discussions with topics spanning sepsis/bacteremia, VTE prophylaxis, and prevention of central-line infections.
SMMC	**Developing the workforce and engaging teams** • Team huddles are used as a platform to discuss current state, care coordination outcomes, and overall metric improvement. This team time is also a venue where staff highlight opportunities for improvement and engage with each other to test and implement change using scientific problem solving. **Improving data capture** • SMMC has created structured fields within the electronic health record, which has allowed for improved reporting outcomes, monitoring of quality, and will lessen the dependencies on chart reviews moving forward. **Strengthening and spreading standard workflows** • Efforts are still in place to ensure appropriate skin preparation, accurate documentation of surgical classification, hand hygiene, and wound care. A new policy has been created to drive the use of chlorhexidine gluconate (CHG) bathing before surgery.
UCD	**Strengthening and spreading standard workflows** • Rolled out a new CLIP form in December 2018, which has provided better documentation around central lines and allowed for a reduced reliance on manual chart abstraction. **Developing the workforce and engaging teams** • UCDH has formed an SSI focus group, which has been working on the standardization of correct antibiotic selection and timing and have done deep data dives on colon surgeries and hysterectomies to identify fall out cases. **Leveraging data** • UCD is in the process of creating a dashboard to show de-identified data for antibiotic selection and timing. **Educating providers and staff** • UCD continues to educate staff around appropriate discontinuation of central lines.
UCI	**Strengthening and spreading standard workflows** • Infection Control worked with key clinicians (ED, OR, ICU, PICC Team) to promote the use of the CLIP form for all CL insertions through various clinical committees. **Identifying and addressing care gaps** • For all identified NHSN CLABSI cases, a review of CLIP compliance is included in the "Acute Cause Analysis" review and feedback is given to clinicians who are non-compliant. • All stroke cases (Ischemic and hemorrhagic) are discussed at the multidisciplinary weekly stroke case conference to review quality and consistency of stroke care. The data is shared with attendings, residents and nursing staff and posted on the UCI SharePoint for all employees to access. **Developing the workforce and engaging teams**

	• UCI's antimicrobial stewardship committee meets regularly to review performance on key quality outcomes and implement improvements such as EHR order sets for appropriate medication selection and system-wide guidelines for prevention and appropriate antibiotic treatment. Harm events including hospital-acquired infections are monitored on the organizational performance scorecard at executive and operational quality committees and discussed daily in morning huddles with clinical and executive leadership. **Aligning with other institutional initiatives** • Oversight and management of the QIP program was integrated into existing PRIME governance Steering Committee and Executive teams, leveraging existing clinical and bioinformatics teams' expertise
UCLA	**Improving data capture** • Created and roll out a new discreet field in the EHR for information related to sterile techniques used during CVC insertion procedures.
UCSD	**Improving data capture** • A registry was implemented in PY2 to help improve the tracking and outreach of patients. **Strengthening and spreading standard workflows** • Enhanced Recovery after Surgery (ERAS) interventions were implemented to further reduce complications after surgery. • Revised VTE order sets to improve adherence are awaiting build and implementation. • A stroke program coordinator follows all stroke patients throughout their hospitalization and communicates regularly with the provider team to reinforce appropriate antithrombotics at discharge. **Educating providers and staff** • Increased educational efforts to improve compliance with good insertion technique and after care. There is now a designated nurse champion in each unit to provide education. • Providers and staff were educated on antithrombotic medication orders at discharge during the Monthly Neurology Residents' Stroke Conference. Staff have also been educated to the importance of early intervention with antithrombotic therapy during hospitalization.
UCSF	**Strengthening and spreading standard workflows** • Adapted and implemented Antimicrobial Surgical Prophylaxis Guidelines. • Implementation of an enhanced EHR Smartform for documentation of sterile techniques for CVC insertion. • Optimized order sets for VTE prophylaxis for surgical cases.
VCMC	**Strengthening and spreading standard workflows** • PY2 improvement focused on improving documentation of appropriate VTE prophylaxis through education and feedback regarding best documentation practices. To facilitate physician use of best practices, VTE prophylaxis was incorporated into the pre-operative order sets in the EHR. • This project year, VCMC updated and integrated the CLIP form into the EHR and continued nursing education regarding consistent use of the form as well as documentation.

QIP PY2 Improvement Activity Themes

Identifying and addressing care gaps	•Systems are developing registries, creating best practice alerts and pulling customized reports to review and address care gaps. •Fall out cases are being reviewed and addressed in committee and interdisciplinary workgroup meetings.
Improving data capture	•Systems are working on improving data capture through the creation of discrete fields, structured data entry and training/education around standardized documentation.
Leveraging data	•Systems are working with their Medi-Cal Managed Health Care plans to share data in order to improve measure performance. •Reports and registries are allowing for the continued identificaiton and outreach to patients who are out of compliance.
Strengthening and spreading standard workflows	•Systems are implementing best practice guidelines, clinical decision support and algorithms to guide evidence-based practice. New order sets, best practice alerts and health maintenance reminders have also been integrated into workflows to guide decision making.
Improving access to care	•Clinic services and availability are being expanded to support patient needs.
Aligning with other institutional intitiatives	•Systems are coordinating with PRIME project teams where appropriate to share best practices, lessons learned and to ensure there is no duplicative efforts. Systems are also building upon work with other grant programs and regulatroy activities.
Expanding patient outreach and engagement	• Reports and registries are being utilized to help track and provide inreach and/or outreach to patients with specific conditions or needs.
Educating providers and staff	•Systems are monitoring provider compliance with metrics and providing real-time feedback to providers and staff to ensure adherance to clinical recommendations.
Developing the workforce and engaging teams	•Dedicated staff are being hired and existing staff engaged to oversee measure improvement activities.

Key QIP Challenges

- Sustained cross-department communication and collaboration
- Lack of accurate documentation of complex care situations
- Lack of discrete fields to capture key metrics
- Lack of guidance to exclude patients with medical contraindications for therapy in the measure specifications
- Manual chart review and abstraction, which is labor and time intensive
- Lag in data reports make tracking and timely intervention difficult
- Data abstraction from multiple sources