



DELIVERY SYSTEM REFORM INCENTIVE PAYMENTS (DSRIP) PROGRAM

DY9 ANNUAL REPORT

OCTOBER 2014

At Contra Costa Regional Medical Center and Health Centers, CCRMC and HCs, we are focused on our mission of delivering high quality patient- and family-centric care with a strong commitment to community. We also strive to be a system that is dedicated to continuous improvement in order to better serve our patients and the wider community.

A foundational aspect of our mission is the Delivery System Reform Incentive Payments (DSRIP) program – a joint state and federal public health system performance improvement initiative that is now entering its fifth year. The DSRIP is part of California's Section 1115 Medicaid waiver and requires 21 public and academic medical centers statewide to achieve an average of 217 milestones in five categories in exchange for at-risk dollars. The DSRIP categories are: Infrastructure Development; Innovation and Redesign; Population-Focused Improvement; and Urgent Improvements in Care. An optional fifth category, HIV/AIDS Transition Projects, was an 18-month program completed in December 2013.

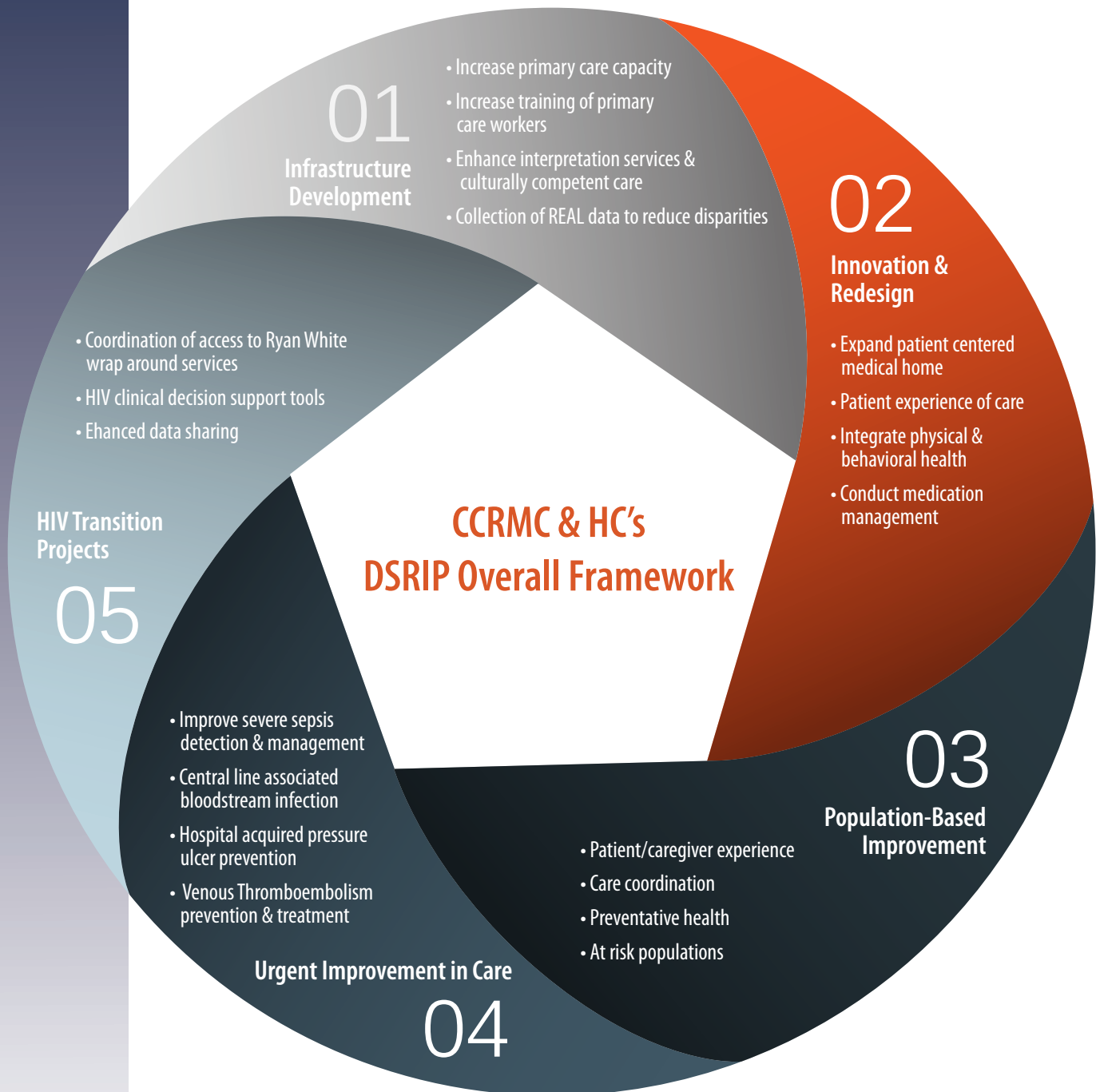
The DSRIP has provided CCRMC and HCs a roadmap to performance improvement, engaging all of our caregivers and employees to embrace innovation and whole-system change in order to improve the experience our patients and families receive. As part of this process, we are enthusiastic participants in a national movement towards population health management so we can intervene earlier and help our community members stay well, rather than being a last-resort stop for advanced disease treatment.

This annual DSRIP report highlights the achievements and challenges of our ongoing journey of system improvement. This reporting year, we reached 59 milestone target measures across 20 improvement projects. These results require a multidisciplinary effort that includes physicians, registered nurses,

pharmacists, information technology specialists, social workers, dieticians and other specialist caregivers, residents, support and clerical staff, quality managers, administration and everyone else who works inside our walls.

We look forward to successfully completing the first phase in our DSRIP journey this coming year, and embarking on a second phase of our partnership with the state and the federal government to achieve mutual goals in health delivery performance improvement.





Milestone Results & Progress

Four years into the DSRIP, Contra Costa Regional Medical Center and Health Centers, CCRMC and HCs, has successfully laid the foundation for delivery-system transformation. We have built the structure to support care quality and innovation for decades to come.

This structure includes the following elements that have been important for DSRIP milestone completion: Flexible and modern IT systems; improved staff communication; a team-based approach to problem-solving; and cutting-edge training so team members can introduce, monitor and evaluate new programs effectively.

Prior to the DSRIP, it was difficult, if not impossible, to implement system-level changes or sustain changes in individual departments. The DSRIP has been the crucial element to engage and support improvement work and drive innovations that were previously unattainable. Our caregivers, administrators and front-line staff are dreaming big and now have the tools to make those dreams a reality for our patients, their families and our wider community.

For instance, our ambulatory care redesign is improving access and consistency in patient care. We added an average of 310 clinic visits per month from DY8 to the first six months of DY9. In this reporting period, our new appointment scheduling system has reduced average hold times from 15 minutes to 4 minutes. Our 'third-next available appointment' rate has been cut by half at one outpatient clinic - from 16 days to 8 days. Our family practice continuity rate rose from 67% to 75% at one outpatient clinic, resulting in 111 more patients per month who have their appointment with their primary care provider. This reporting year, we began moving providers into more focused roles in either inpatient or ambulatory care settings to allow for improved care continuity for empaneled patients.

Our migration to a Patient-Centered Home Health (PCHH) model also has improved care continuity for our patients. As of June 30, 2014, 99.69% of Full Scope Medi-Cal and Low Income Health Plan (LIHP) individuals have been assigned a primary care provider. We continue to track and display patient satisfaction results at our outpatient clinics, boosting awareness and understanding for our caregivers and patients.

On the inpatient side, we are taking a "no stone unturned" approach to harm reduction. This reporting year, we moved beyond the initial work of setting, meeting and exceeding baseline targets in patient safety. We are now seeking and addressing areas for improvement that will elevate our care delivery to zero harm. For instance, our sepsis team this reporting period focused on strengthening inpatient sepsis management and training. This included creating a new inpatient sepsis committee, and developing inpatient-specific sepsis protocols and order sets. Our one-hour bundle compliance rate increased to 72% this reporting year, up from 51.3% in DY8. Our mortality median for sepsis this reporting year was 8.4%, down from 11.5% in DY8 and 18% in DY7.

All quality and safety improvement teams this year turned their attention to standardization of policies, procedures and tools to reduce human-factor lapses. This means making sure success doesn't hinge on a certain department or unit or even specially trained caregiver. Instead, systems are in place that set up all front-line caregivers for success, and allow us to more effectively track patients so we can conduct *harm prevention*, rather than *harm reduction* strategies. Examples of this are new dressing kits for central-line patients that fit into standard workflow and shorter compression socks that boost compliance for patients at risk for venous thromboembolism.

Lessons Learned & Key Changes Implemented

Today, we are becoming a system that produces health, not projects. This shift has been the most important change derived from the DSRIP. We are now a system that can take on new and innovative approaches to entrenched problems, implement these approaches, study them and know whether they are working for our patients and community.

For instance, an important aspect of ambulatory care redesign is building a bridge between the medical home and wider community resources available to patients and families. In June 2014, we implemented a program that links patients in need of non-medical services that can impact health -- including transportation, housing, food and heat -- to community resources that can help. This program enables physicians and other primary care providers to "prescribe" basic resources such as food, and then patients take this prescription to a designated desk located on site at our West County health center. Twenty-three students from the University of California at Berkeley staff the desk a total of 161 hours each week. This program incurs no additional cost to CCRMC or our patients. From June 2014 through late August 2014, there were 232 referrals to this program. By far the greatest need among referred patients is food. The program is successfully securing food for our patients, and providers are expressing enthusiasm for the program. At long last, our providers are able to offer a solution to patients for non-medical problems that negatively affect their health.

This initiative could not have happened without the DSRIP. The DSRIP laid the foundation for system change that allowed us to integrate community resource referrals into physician workflow. Thanks to the DSRIP, our ambulatory care teams already knew how to conduct PSDAs (Plan, Study, Do, Act) when the opportunity presented itself. With this valuable training, we were able to assess and implement the program with ease. Through our EHR, cLink, we are tracking community referrals and results. We are now studying the impact on our patients, our providers and the CCRMC system, as well as the community as a whole.

As hospital systems become more responsible for the overall health of the communities they serve, they must have the resources and knowledge base to be able to create and sustain meaningful partnerships with outside organizations. Community referrals are one example where we are fulfilling our mission to improve the health of the communities we serve in Contra Costa County.

This focus on community-centered care is part of the overall transformation happening in ambulatory care. We are redesigning our ambulatory care clinics to improve access, outcomes and patient satisfaction. For instance, at two health centers today we have behavioral health and physical health under one roof, and are screening primary care patients for possible depression or substance abuse using evidence-based practices. Increased attention to behavioral health issues, combined with on-site resources for patients identified as at-risk, are helping to improve the health of our patients and our communities.

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Integrating Behavioral Health & Physical Health to Improve Community Health

Untreated mental and behavioral health needs such as depression, anxiety and substance abuse can increase a person's risk of developing a chronic medical condition. It can also lead to poor quality of life, a shortened lifespan and more trips to the emergency department.

At Contra Costa Regional Medical Center and Health Centers, CCRMC and HCs, we are implementing programs that make it easier for our community members to get diagnosed and receive treatment for behavioral health needs.

We are accomplishing this by co-locating primary care and behavioral health services under one roof; using evidence-based tools to conduct comprehensive patient assessments to identify behavioral health conditions; improving the patient referral process; and engaging community stakeholders to provide whole-person services.

In the past year, we opened two integrated wellness centers that offer both physical and behavioral health services. The first center opened at Concord Health Center in November 2013, and the second center is the new George and Cynthia Miller Wellness Center in Martinez, which opened in May 2014.

Both centers offer primary care, group medical visits, same-day medical appointments, psychiatry services, short-term individual and family therapy, support groups, referrals to long-term care, crisis management and outpatient care for substance abuse.

"The goal is that every door is the right door to our services," said Dr. William Walker, CCHS Director.

"The idea is that if someone comes in for a medical visit, they also will be able to have their physical and behavioral care needs met in one place."

Patient screenings to detect behavioral health issues are one aspect of the integrated approach. A DSRIP project is focused on implementing a depression and substance abuse screening tool into primary care visits.



The federal Substance Abuse and Mental Health Services Administration developed the screening tool.

Between July 2013 and June 2014, nearly 600 patients were screened for depression and substance abuse during a primary care visit. Those patients who are identified through the screening tool as at-risk for depression or substance abuse are referred to specialist services for follow-up care on site.

Tim Tarman, a Walnut Creek resident who has suffered three strokes, received a referral from his primary care physician at Concord Health Center for a therapist to help treat depression. Tarman also attends group therapy at the health center.

"Every single day I feel something that reminds me of my strokes, but it's about appreciating where you are today," Tarman said. "I have gotten the care I need and even more critical are the people here. This is a wonderful place. My strokes were life-changing but so is the care I have received here."

Integrating behavioral health with physical help can put patients on the path to total health and also contribute the improvement of the entire community, said Cynthia Belon, Behavioral Health Director for Contra Costa County. "We know well that mental and physical wellbeing is essential to overall health," Belon said, "And it is exciting to see our ideas reflected broadly in our health care system."

Barriers, Challenges & Strategies

The biggest challenge that we have faced has been changing the mindset of our staff members and caregivers. For every staff member who has embraced delivery-system transformation wholeheartedly, others we have had to help along the path. An example of a mindset change is seeking approval to hire a new FTE to run a project rather than redesigning and training the existing team to do the work. While more staff may be necessary, we must first start with the resources we have before building out.

Sometimes, a mindset change requires new thinking about old ways of doing things. For instance, we have held a series of training sessions for our ambulatory care nurses to increase awareness about behavioral health issues that may present themselves in primary care appointments. Nurses must become more comfortable in asking behavioral health questions during routine visits in order to better serve the whole patient. In addition, we are tasking caregivers to think more about the patient beyond the walls of our institution in order to transform into a care organization that serves our community. Primary and behavioral healthcare integration is not just a DSRIP project, it is a paradigm shift in care delivery. And it is one we believe is necessary to strengthen our community members so they can have the foundation and support to achieve all their goals, whether personal or professional.

We have also faced challenges in developing new initiatives that fit into provider and staff workflows. Implementing proven methodologies to pilot new ideas has helped us to learn what solutions work and what others are too cumbersome for long-term implementation. Spreading these ideas beyond initial pilot sites can also be challenging because it requires on-boarding from other teams that are already busy with their own projects and programs.

The DSRIP itself has helped immeasurably to elevate processes and projects in order to get buy in from line staff. For instance, improving prevention of venous thromboembolism (VTE) has long been important to our organization. But the DSRIP raised awareness about the issue of VTE among staff members and physicians, and reprioritized prevention strategies while improving engagement. As a result, we have been able to rapidly implement improvements to VTE prevention, and these changes are being met with enthusiasm from staff members and physicians.

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Stakeholder Involvement Process

During this reporting year, we have continued our focus on inclusion of stakeholders such as physicians, patients and families to advance our improvement work.

We have reached out to key physicians on each DSRIP project and included them on teams and committees. Most have become vital members of our improvement efforts. For instance, this reporting year we developed an inpatient sepsis committee that included stakeholders on inpatient units to develop sepsis response protocols that fit in with the workflow of physicians, nurses, residents and pharmacists. On the outpatient side, physicians working with HIV have provided valuable input for developing best practices on HIV patient management.

Also this reporting year, we included 100% of both first- and second-year residents in quality improvement learning sessions. The residents continue to receive didactic education on improvement theory and we increased engagement by focusing on resident-identified improvement projects. Our residents are conducting PDSAs (Plan, Do, Study, Act) independently at clinics. Additionally, we continue to expand Family Medicine residency classes to raise our capacity for primary care.

In regard to patient and family involvement, we continue to have success in recruitment and retention of volunteer patient and family members to serve on our advisory councils and participating in rapid-improvement exercise (kaizens). Our Patient Experience Partnership Council included three patients and family members, who worked with us to determine gaps in care or services, then take recommendations, set priorities and hold focus groups for added feedback before implementing changes. Additionally, our Behavioral Health Partnership Council, which also includes patients, families and community members, has been instrumental in our DSRIP work to integrate behavioral care into primary care services. We also have a Perinatal Breastfeeding project and a Spiritual Care Council that both include patients as vital members.



A “Health Home” for Every Patient

Contra Costa Regional Medical Center and Health Centers, CCRMC and HCs, is among the 21 public hospitals in California that is modernizing its ambulatory care services to better serve patients and improve outcomes.

Called Patient Centered Health Homes, PCHHs, this approach delivers the right care to the right patient at a location patients prefer. The key factors that differentiate a PCHH from a standard medical practice are:

- Assigning all patients to a primary care provider for consistency in care
- Using team-based care under the direction of the primary care provider to maximize and expand the levels of care available to the patient
- Implementing electronic disease registries on chronic conditions such as diabetes to give care teams tools and data to offer appropriate and culturally competent care and better manage the health of populations
- Improving access by providing alternative care models such as telephone consultations with primary care physicians
- Improving patient flow through the standardization and streamlining of intake processes, referral tracking, prescription refills and behavioral health screenings

Transforming our ambulatory care centers to PCHHs involves multiple DSRIP projects. Starting with these projects, the transformation has spread so that our overall approach to primary care services is light years away from where we were when we began this journey four years ago. In addition, we are proud to be continuing our partnership with the Institute for Healthcare Improvement (IHI) on our ambulatory care redesign project, tapping into national resources for training, tools and best practices that have put us firmly on the path towards a better outpatient experience for our patients.

For instance, today more than 99% of newly enrolled Medi-Cal patients are immediately assigned a primary care provider. This has been possible with the rollout of PCP Central, a database that matches providers with patients at a location convenient to them. We continue

to reorganize care teams and provide supportive training to better serve patients under the health home model. We also increasing primary care training in low-income/diverse areas. This year, Family Medicine residents conducted more than 12,200 clinic visits.

In the past year, we have added an average of 310 clinic visits per month, improving access to our patients. We continue to see success of our Telephone Consultation Clinic (TCC), with a 94% patient satisfaction rate, and also schedule phone visits with providers for patients who don't require an in-person visit. Both these programs free up valuable in-person appointment slots for patients that truly need them. Technology enhancements in appointment scheduling such as automated reminder calls and automated canceling and rescheduling have also improved access and workflow.

With the opening of the George and Cynthia Miller Wellness Center in Martinez in May 2014, we can provide an expected 70,000 outpatient visits annually at this site, in addition to our other 10 health centers located throughout the county. We are also gradually decreasing patient panel size of our family medicine providers to improve access.

In June 2014, we launched mycclink, an online patient portal where Contra Costa Health Plan members can email their doctor, view most lab test results, request prescription refills and access other medical record information securely on the Internet.

We are continuing to use our patient registries of chronic conditions to optimize care and improve population health management. The development of dashboards, reports and other tools is helping us to identify patients who are candidates for higher-level interventions for chronic care treatment and also monitor the overall health of the population we serve to make sure we are constantly improving.

“Improving access and developing our workforce will help us meet our goals of providing better care for patients, improving the care of our communities and lowering costs,” said Anna Roth, chief executive officer of CCRMC and HCs.

Training Programs

CCRMC and HCs is an enthusiastic participant in training programs for our staff and physicians. We are mindful of the myriad training programs available today and strive to expend limited resources and time on the most targeted and impactful programs.

The Kaiser Permanente Improvement Institute is one example. The KP Improvement Institute spreads learning from the integrated care organization's successes. Fellows learn principles in a "top down, bottom up" approach to reduce variation in care delivery and support learning and improvement. Training includes developing deeper capability and planning to achieve big results over time.

Our participation in the KP Improvement Institute has resulted in several noteworthy projects that are coming to fruition. Our walk-in mammography clinic, an idea that came out of the KP Improvement Institute, is improving screening rates and patient satisfaction for this DSRIP Category 3 project. The walk-in program launched in May 2014 at CCRMC in Martinez and the West County health center and is improving access for patients. The walk-in service has so far has resulted in two or three additional mammography screenings per day at Martinez. We are now developing a "walk-in" field to add to the EHR to track data on walk-ins and develop more strategic programs to improve screening rates.

Additionally, our partnership with the Institute for Healthcare Improvement (IHI) on our ambulatory care redesign has been important to our success. IHI coaches our teams via an improvement collaborative at four of our nine ambulatory care sites in an ongoing collaborative.

One of our primary goals is to ensure that our staff has the opportunity for leadership development. Our Change Agent Fellowship, developed internally and launched in 2009, is a 15-month leadership training program that aims to create a new vision for CCRMC and HCs to meet the rapidly evolving challenges of today's healthcare delivery system. Fellows learn to apply Lean methodology and Institute of Medicine Safety Aims, as well as learn quality and measurement, public speaking, team building, coaching and mentoring and time management. This reporting year, nine fellows participated from all departments and professions. Fellows are accepted every two years into the program.

While the Change Agent Fellowship is not directly related to the DSRIP, it is a foundational program that is helping our staff to conduct improvement work. Armed with this knowledge, our staff can more effectively manage DSRIP projects because they have the tools necessary to track, measure and monitor results.

We are committed to conducting ongoing training for new and existing staff in best practices. One example is in interpreter services. We conduct regular interpreter services trainings, particularly for specialty care and procedures, to ensure that interpreters adhere to our high standards. We train interested bilingual staff in other departments to become certified medical interpreters on the HCIN network, and continue new provider and staff orientation and training on utilization of interpreter services. And when we receive complaints about interpreter access from patients or family members, we conduct refresher on-the-spot training. A commitment in ongoing training is now business as usual at CCRMC and HCs.

Approaches to Test or Refine Interventions

We have implemented industry-standard approaches to test or refine interventions aimed at improving care delivery and efficiencies. These approaches include PDSAs (Plan, Do, Study, Act); forming trained pilot teams to test new ideas; and using efficiency initiatives such as 5S, a Lean improvement concept that stands for sort, set in order, shine, standardize and sustain.

For instance, in expanding capacity at our ambulatory care clinics, we have faced a number of challenges including complex and non-standardized workflows in the clinics and appointment units that slow improvement. In response, we created four teams at four model health centers to develop standard work for optimal team-based care. We then spread these tested improvements in a stepwise and deliberate manner. We found that identifying and removing non value-add steps in the process can streamline care and increase capacity.

On the inpatient side, we are continuing to devise new ways to conduct harm prevention by placing harm prevention tools within the workflow of our caregivers. One example is in venous thromboembolism prevention. This reporting year, we conducted a PDSA on sequential compression device (SCD) machines, which apply pressure to leg muscles and compression to veins to prevent blood clots. These machines are important to reduce risk of VTEs but they were not always readily available for caregivers. Instead, the machines would have to be ordered from materials management and sent over to the requesting unit – a time consuming process.

In the PDSA, we tested two SCD machine accessibility approaches: in an 8-bed telemetry unit, we tested having SCD machines located at each bedside. On the ICU and IMCU, we tested having two machines in designated areas in both units on standby at all time. The telemetry bedside test cut SCD machine wait times from an average of 5 hours to just 5 minutes. The designated area standby test has resulted in no VTE failures and no near-misses on these units. Our goal in the next reporting period is to spread this learning to other hospital units and make SCD machines more readily accessible to attending caregivers.



Preventing Life-Threatening Blood Clots

Life-threatening blood clots, known collectively as venous thromboembolism (VTE) are a leading cause of preventable death and injury nationwide. Nearly 1 million people are affected by VTE each year in the United States.

Preventing VTE is a major patient safety focus at Contra Costa Regional Medical Center. VTE occurs at a very low rate at CCRMC, but we have implemented a system of consistent and rapid assessment of risk for VTE. This effort is part of our overall system transformation effort in partnership with the state and federal government, the DSRIP.

CCRMC has an interdisciplinary team that is dedicated to preventing VTE among at-risk patients. Some of these team members have personal experiences with VTE.

Jenne Gossett, registered nurse and chief nursing informatics officer, experienced a life-threatening VTE in 2008 after falling and breaking her leg. She underwent knee surgery after the injury and within a few days developed a pulmonary embolism (PE), a blood clot in her right lung. Her symptoms were similar to pneumonia – fatigue, a fever, back pain, shortness of breath and a “crackling” sound in her lungs. A quick-thinking physician spotted the warning signs of VTE and sent Gossett to the emergency department, where a CT scan revealed not only a large lung clot, but a blood clot that extended from her pelvis all the way down her leg and other small clots in her lungs.

“He didn’t expect me to live through the night,” Gossett said of her attending physician. But she did, with the help of blood-thinning medication that broke up the clots. Six years later, Gossett still has shortness of breath and permanent damage to her leg. Today, she works with a team of other registered nurses, physicians and pharmacists to help prevent VTEs in other patients.

Evidence-based best practices include quick administration of blood thinning medications; shorter compression socks that help prevent leg clots; and protocols to make sure patients begin sitting up and



walking as soon as possible after surgery. The VTE team on a daily basis review electronic medical records of patients being treated at CCRMC to ensure they are receiving proper treatment to prevent VTEs. Today 100% of patients in the intensive care unit receive proper preventative treatment for VTE, and other units have a success rate of over 98%, and 100% of patients with VTEs receive appropriate blood thinning medication.

Pat Christy, registered nurse and quality manager who leads the VTE effort, personally conducts daily audits on all new patient charts to make sure that at-risk patients are receiving proper VTE preventative care. “We have to be perfect,” Christy said. “We have to be exceptional.”

The path to performance improvement is not always smooth, and the VTE team has worked hard to implement policies and systems that make preventative efforts automatic for front-line caregivers. Additionally, the team has improved discharge planning for patients on blood-thinning medication so they have education on their medication and understand its importance in preventing blood clots when they return home.

John Jones, registered nurse and quality manager who is also in the VTE team, said CCRMC has an institutional commitment to eliminating VTE risk.

“From my perspective, our single biggest accomplishment is one that is difficult to measure,” Jones said. “It’s the change in the culture.”

Plans for Sustainability

Our participation in the DSRIP has taught us some key ingredients for sustaining improvement over time. To be sure, enthusiasm for projects can wear off, and new projects can take precedence as hard-won improvements become routine. Sustained results must be baked into workflows and reinforced in trainings. Some strategies that we use to sustain results over time include:

- Creating a learning environment that is interdisciplinary, structured and dynamic
- Empowering the front-line staff to give feedback
- Leveraging IT to support data collection and present that information in a meaningful way to providers in order to sustain progress and identify trouble spots before they reverse gains
- Building decision-support into the process and make it highly visible, such as checklists and best practice reminders
- Continually engage with community partners to make sure that everyone remains on the same page
- Conducting monthly and quarterly data monitor of patient progress to ensure continued success and compliance rates
- Employing outreach staff to communicate regularly with patients who need extra support to maintain their care plans

Category 5 is an example of where we have implemented the above strategies to continue refining and improving care for HIV patients in our community after the sunset of this DSRIP project. Maintaining care compliance for this population is a pressing concern, especially since many of our HIV-compromised patients face challenges with housing, employment and other daily needs that can adversely impact their health. About 13% of our HIV-compromised patients struggle with mental health issues and/or substance abuse and therefore have difficulties complying with regular lab testing and drug regimens. We will continue outreach efforts to patients via LVN care coordinators with personal reminder calls. Additionally, we give providers monthly updates on measure compliance rates and do monthly case management rounds to manage individual patients with unsuppressed viral loads.

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Ongoing support by the DSRIP Executive Team and Hospital and Health Center leadership of the improvement champion's work in monitoring and challenging the front line staff is another example. We have found that crucial advancements in patient care need both data to evaluate whether improvement has occurred and improvement team support to embed the practices in daily workflow. Without leadership that takes an active role in supporting the improvement teams and breaking down barriers, those gains begin to falter. Our Patient Safety and Performance Improvement Committee, a medical staff run improvement committee, has also been making great strides in taking a greater role in supporting all organizational improvement efforts. This committee's forward-thinking efforts uniquely position them to support all improvement projects long-term.

System-level Changes Resulting From DSRIP Projects

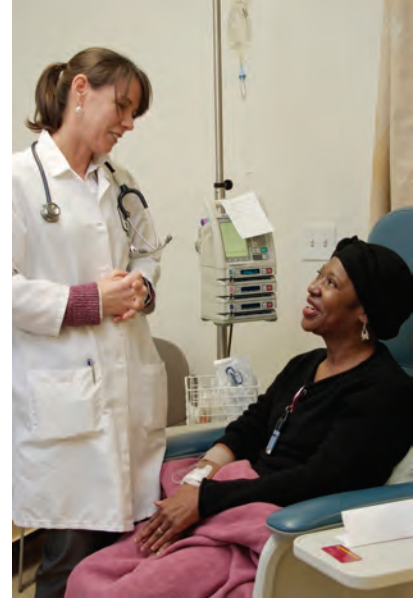
The improvement work we've done since the start of the DSRIP has culminated in a system-wide shift in how we interact with our patients, our community and with one another internally. All of these efforts are being closely examined and monitored. In this reporting period, we began an internal dialogue on the future of this transformative work and how it fits into our organization's mission and strategic plan. The DSRIP is a starting point for improvement, and it has allowed us to embark on a wider journey of transformation. With this in mind, we are currently developing a strategic plan that has three priorities:

1. Patient- and Family-Centered Care
2. Continuous Improvement
3. Community Commitment

The DSRIP projects and the work that has grown out of the DSRIP reflect these three priorities. These include partnering with patients and families to create optimal care through shared decision-making; actively encouraging all staff to evaluate, question and challenge themselves to improve systems, practices and outcomes; and defining and upholding a standard of value respectful of the community's trust in CCRMC.

An example of a system-level change that derives from the DSRIP and is reflected in our strategic plan is our new welcoming policy. CCRMC is one of 12 hospitals that in June 2014 was recognized by the Institute for Patient- and Family-Centered Care (IPFCC) as an exemplar hospital in family inclusion. CCRMC's welcoming policy, implemented in late 2013, eliminated restrictive visiting hours and changed the concept of families as "visitors." Today, families are welcome 24 hours per day, 7 days a week. Family members are also included in care decision and patient preference discussions with care providers. Safety and patient wishes are always paramount in every situation, and the hospital maintains a 'quiet time' between 10 p.m. and 7 a.m. to promote restful healing. But the goal of the welcoming policy is to reflect the patient wishes on who should be present for emotional support and as a team member on care decisions. We believe that excluding family members from these important decisions and moments is an outdated concept that does not promote healing.

The welcoming policy is just one example where the fundamentals of the DSRIP of improved access, better care quality and increased patient satisfaction are taking root within and outside our walls.



Shared Learning

Institute for Healthcare Improvement (IHI):

CCRMC and HCs continued our partnership with the Institute for Healthcare Improvement that began in May 2013 to improve care for our patients within our Ambulatory Care system. The project, known as Ambulatory Care Redesign (ACR), is an ambitious effort to improve how we deliver outpatient care by blending best practices with optimal care for the best patient outcomes. This mission brings the IHI's expertise to frontline staff to learn about improvement tools, and share design ideas and best practices.

Integrated Nurse Leadership Program (INLP):

Successfully completed our participation in the INLP Sepsis collaborative, funding by the Gordon and Betty Moore Foundation, on September 30, 2013.

Improvement Institute:

The CCRMC and HCs continues this weekly forum for improvement teams to meet for information sharing and training. Topics include report writing, PDSA documentation, and resistance to change along with practical approaches to overcome issues typical to improvement activity. Improvement team members and Unit Champions are encouraged to incorporate what they have learned into practice and to seek the buy-in and the assistance of front line staff. This forum also creates a platform for shared learning between teams particularly regarding PDSA successes and has had the effect of reinforcing the value of reaching out to other DPHs on shared learning. In November 2013, the DSRIP teams reported out to the Improvement Institute progress so far on DSRIP milestones.

Other shared learning:

CCRMC's Pharmacy Director shares regularly the topic of medication management efforts with peers via local professional organizations such as the Diablo Chapter of the California Society of Health-System Pharmacists; through statewide and nationwide presentation, presenting work performed on this effort (e.g., Avoid Readmissions conference).

Our sepsis team presented and shared sepsis management strategies on July 31, 2013, at the SNI Sepsis and collaborative capstone event. In November 2013, the sepsis team shared its "best practice alert" with University of California San Francisco. And the sepsis team participated in a webinar from the Society of Critical Care Medicine "Use of Corticosteroids in Sepsis Shock" on June 2, 2014.

CLABSI team members attended the annual convention of the Association for Professionals in Infection Control and Epidemiology (APIC) in June 2014 on CLABSI best practices. The CLABSI team also attended educational sessions with the SNI, America's Essential Hospitals and Target BSI (Blood Stream Infections). The team shared with the Essential Hospital Engagement Network (EHEN) difficulties with a patient who deliberately sabotaged his central line.

The HAPU team implemented a shared learning tool for surgical/procedural positioning communication between the PACU and OR. The tool was acquired from the Aultman Hospital in Canton, Ohio, via communication with America's Essential Hospitals.

The VTE team participated in a Webinar on VTE prevention and measures by America's Essential Hospitals in May 2014. The team continues its ongoing communication with Kern Medical Center (KMC) in Bakersfield, CA. The VTE team has reviewed KMC's processes for VTE and is adopting those appropriate for CCRMC, including calf-high SCD sleeves.

Contra Costa Regional Medical Center and Health Centers (CCRMC and HCs) is an integrated 166-bed hospital system with 10 ambulatory care health centers. Contra Costa County is comprised of a diverse population of approximately one million residents. CCRMC and HCs is the primary medical provider of over 100,000 individuals, with 450,000 outpatient visits, 57,000 Emergency Department visits, and 10,000 hospital discharges annually. We also deliver 13% of Contra Costa County's babies. Our payer mix is 46% Medicaid, 12% Medicare, 38% managed care and 4% other. We have 450 physicians and train 42 Family Medicine residents yearly who provide care throughout the health system – in the Emergency Department, hospital, hospital-based outpatient clinics, and freestanding health centers.

cchealth.org/medicalcenter