The DSRIP has served as the runway for us to take flight in our performance improvement journey. It set the stage for dramatic strategic improvements that will fundamentally improve care and efficiency throughout our system.

Our goal is to deliver quality, equitable care to our community members. Compassion, respect, dignity and partnership are not just words — they are guiding principles for care delivery in Contra Costa County.

The DSRIP has allowed us to put into action these principals by expanding access to services, improving care coordination, testing innovative care models, engaging in population health and refining treatment of some of the most serious and life-threatening conditions to improve outcomes.

We are pleased to share some of our most recent successes, challenges and lessons learned from the final year of this program.
MILESTONE RESULTS AND PROGRESS

In the fifth year of the DSRIP, we continue to improve upon our prior efforts to provide quality care that puts patients at the center.

Ambulatory care redesign remained an important focus. This past year, we enhanced our Patient-Centered Health Home (PCHH) model by implementing tested ways to improve patient access, quality and experience. Our average clinic visits per month increased by more than 2,000 average visits per month this reporting year, to an average of 15,246 visits per month.

With the reality of increased clinic visits, CCRMC redoubled efforts to reduce wait times to see a provider. Our median days for the "third next available appointment" fell from eight days to two days at the North Richmond Health Center; from 16 days to 10 days at the Martinez Health Center; and from more than three weeks to eight days at the Miller Wellness Center, also in Martinez.

Our new appointment model allows greater control over scheduling and frees up appointments for those in greatest need, contributing to our improvement in appointment wait times. Additionally, our Telephone Consultation Clinic (TCC), where providers consult with patients over the phone, continues to be a huge success. In calendar year 2014, the TCC served 6,703 patients, and of those, 75.5% had their healthcare needs met through the TCC alone. Patient satisfaction of the TCC remains high at 96.57%. This success is largely due to our ability to leverage our partnership with the Contra Costa Health Plan and secure their managers' and advice nurses' support and input.

Consistency of care and establishing and maintaining trust between patient and providers continue to be a central focus in ambulatory care. This reporting year, we spread the "Establish Care RN" (ECRN) visit for new patients entering our health system to the two Martinez health centers. The Establish Care nurse specializes in preparing the patient for their first in-person appointment to better support the work of the provider in clinic. Under this protocol, the ECRN calls the patient in advance of the appointment wait times.

15% increase in average clinic visits per month, to 15,246 visits per month

97% patient satisfaction rate with the Telephone Consultation Clinic (TCC)
appointment to collect detailed medical history, perform the health needs assessment and obtain outside medical records.

This reporting year, we spread the screening of primary care patients for depression and substance abuse to one additional clinic. Additionally, we screened 80.5% of the pilot primary care provider panel for depression and substance abuse, up from 57% in 2013-2014. To improve care continuity, we provided EHR access and training to psychiatrists in the county’s behavioral health division so they can conduct medication reconciliation for their patients.

On the inpatient side, CCRMC strives for a perfect record in care quality. Compliance in evidence-based best practices continues to improve in sepsis management, central line associated bloodstream infections (CLABSI), hospital-acquired pressure ulcers (HAPU) and life threatening blood clots, known as venous thromboembolisms (VTEs).

- One-hour bundle compliance for sepsis resuscitation climbed to 80% this reporting year, up from 72.73% the prior year. Meanwhile, sepsis mortality continues to fall, to 6.9% this reporting year, down from 8.4% the prior year, and from a baseline of 18% in DY7.

- Our HAPU prevalence rate was 0.44% this reporting year, thanks to vigilance in assessing patients for pressure ulcers. Our VTE prophylaxis compliance rate this reporting year was 99.37%.
Continuous improvement is now part of our work environment, staff training and culture. In DSRIP projects where we have achieved success, we test, analyze and refine approaches to continually improve patient care.

One example is our mammography screening program. Our rate for mammography screening for females age 50-74 this reporting year was 66.10%. We realize that we can do better, especially with the influx of newly insured into our system because of national health reform. From January to June 2015, there were 1,738 more patients eligible for mammography screening than the prior year.

Reaching eligible patients requires a multi-pronged approach. Last reporting period, we launched a walk-in mammography clinic at three sites. More than 633 women have taken advantage of the walk-in clinics since their inception. We also continued to offer Saturday screenings at two locations on an as-needed basis.

One important but unquantifiable benefit of the DSRIP is our commitment to continuous improvement.

We worked to reduce the wait times to get a mammogram. Our “third next available” appointment for a mammogram in Martinez fell from 30 days in May 2014 to just two days by March 2015. This reduced wait time improved our “no show” rate for mammogram appointments. Our show rate in Martinez was 87% in May 2015, up from 78% in July 2014.

Actively seeking out women eligible for mammography screening was a focus of this year’s activities. We learned to be more assertive in our appointment reminders, while making it easier for our patients to access mammography services. One tactic implemented was sending mammography reminder letters to 800 eligible women per month who are enrolled in the Contra Costa Health Plan. We also trained six health home coordinators at Concord Health Center to schedule mammograms during pre-visit phone calls. Additionally, our staff interpreters record appointment reminder messages in patient preferred languages (including mammogram appointments). As a result of these efforts, the absolute total number of screenings rose steadily this reporting period, to 9,255 total women screened in May 2015 as compared to 7,380 the same time last year.

This multi-pronged and sustained approach to mammography screening is an example of our commitment to continuous improvement.
A recurring challenge of this year’s DSRIP projects is the influx of newly insured patients to our system due to federal health reform.

Five years ago, Contra Costa Health Plan – the first public hospital-sponsored health plan in the nation – had just 88,000 enrollees. Today, we count 185,000 members.

This phenomenal growth is both a challenge and an opportunity. As stipulated in our new five-year strategic plan, CCRMC’s overarching goal is to create optimal health for all. To achieve this aim, we must make sure everyone in our community has access to affordable, quality healthcare. The Affordable Care Act’s provision to get everyone insured through development of the state-based exchanges and Medicaid expansion are therefore essential supports in realizing this objective.

However, the rapid expansion of our insured population has created some “growing pains” around access issues. For instance, our average family medicine provider patient panel size rose by 9.1% this reporting year, from 1,541 to 1,681 patients. We are brainstorming ways to reduce panel sizes while continuing our commitment to assign 100% of new health plan patients to a primary care provider.

Additionally, our median missed appointment rate increased from 16.7% at the end of DY9, to 18.5% this reporting year. Meanwhile, our family practice continuity rate fell from 77.6% to 68.5% over the same time period. At our Antioch Health Center, the “third next available” appointment rate increased from eight to 10 days on average during that time period. And our centralized appointment unit average hold times rose from four to seven minutes.

Our strategies to effectively handle this new influx include enrolling patients in our online portal to facilitate communication. As of this reporting period, 8,170 empaneled patients have activated their Web portal, or 7.5% of empaneled patients.

We continue to reach out to patients in various ways to boost online portal activation. We also enhanced a pilot program of “provider partner teams” at five health centers to improve access. Under this team-based model, providers agree to see their partner’s patients when their partner is unavailable. This model is improving communication and care continuity.

CCRMC is excited about the opportunity to provide high quality care to our newly insured members. We want ours to be the system of choice in our community. While we have experienced growing pains because of this rapid growth, we are starting to see some leveling off. New monthly enrollees to our health plan peaked in August 2014 and have decreased since then.
STAKEHOLDER INVOLVEMENT PROCESS

Stakeholder involvement is now the way we do business.

We involve our clinicians, staff, patients and families and community partners — our “brain trust” — in developing priorities for our organization and implementing plans.

One example is closing disparities in population health. This reporting year, we conducted an analysis on our population health measures for disparities in Race, Ethnicity and Language (REAL). Our analysis indicated four measures with some disparities in care by race: mammography screening; flu immunization; hypertension; and pediatric body mass index.

Our Equity Team — tasked with evaluating every aspect of the organization for REAL equity — chose initially to focus on flu immunization and hypertension in African Americans. This past spring, the Equity Team designated a multidisciplinary group, the Reducing Health Disparities team, to develop work plans to reduce disparities in these two population measures. This team met with the hypertension and flu immunization teams to discuss strategies to improve rates among African Americans for both measures.

The work plans developed for flu immunization and hypertension leverage a broad spectrum of community resources and experts to reduce disparities, including communications professionals, health conductors, front-line providers, provider champions, public health partners and health IT contributors. We have welcomed new and innovative strategies to address these disparities, including more accessible flu shot clinics and hypertension screenings.

Our next steps include a media campaign; connecting with the target population about risk factors and benefits of preventative care for flu and hypertension, and tracking the effectiveness of strategies and evaluating results. We look forward to seeing tangible results to reducing health disparities among our African American patients.

TRAINING PROGRAMS

DSRIP has transformed CCRMC into a continuous learning organization.

A key component to being a continuous learning organization is building capabilities from top to bottom. We build capabilities by giving our staff opportunities to participate in a wide variety of training and leadership programs that can help them achieve their professional goals and continually improve our organization. These opportunities don’t teach a particular approach. Rather, we embrace multiple methodologies.

Our programs include the Nurse Leadership Academy, the Improvement Academy, Change-Agent Fellows, the Kaiser Permanente Improvement Institute and the Breakthrough Collaborative, which focuses on behavioral health integration.

Our Nursing Leadership Academy, for instance, is a yearlong leadership development experience for nurses at CCRMC. A world-class faculty provides in-person and virtual teaching and coaching to participants, with the goals of improving skills and commitment to developing organizational capacity, leading improvement and building effective partnerships.

Our Improvement Academy is another avenue for continuous improvement and leadership training. The Improvement Academy first included DSRIP teams and then mid-level managers on improvement principals. Over the five-year span of the DSRIP, many of our managers received training on the Institute for Healthcare Improvement’s Model for Improvement through the academy. Additionally, our Lean kaizen rapid improvement events — which put the tools of continuous improvement into practice — are important to create standard work. Standard work supports improvement efforts throughout our organization, from hospital units to outpatient clinics.

The positive effects of training programs generated by the DSRIP are far-reaching. Training on how to conduct, test and refine improvement work has set the stage for us to participate in public and private grants that continue to improve our organization. Additionally, this improvement work was vital in the development and rollout of CCRMC’s new five-year strategic plan. The strategic plan offers staff a solid roadmap for prioritizing work around key goals and initiatives while bolstering the organization’s internal management capacities. The CCRMC trainings are being expanded under the strategic plan to ensure greater capacity, input and knowledge at every level of the organization. This not only increases clinical skills but also fosters inter-department and organizational communications and networking capacity for greater efficiency and effectiveness.
As a large teaching medical center, a central mission of CCRMC is training the next generation of physicians to provide high quality and comprehensive care to patients.

And an important aspect of providing high quality care is learning how to test and implement changes that actually improve patient outcomes and achieve organizational goals. This is loosely defined as quality improvement, and at CCRMC, we take it very seriously.

One of our DSRIP projects is focused on including 100% of our first-, second- and third-year residents in improvement projects.

Kendra Johnson, a 28-year-old family medicine resident from Wisconsin, learned about improvement work by serving on the hospital’s sepsis committee. Sepsis — a severe, systemic infection — is the leading cause of death in hospital patients, with an estimated mortality rate of 25% to 50%. The sepsis committee is a group of nurses, physicians and quality managers who are dedicated to improving sepsis detection and treatment.

By participating in the sepsis committee, Johnson learned tools of improvement work, such as how to roll out a new sepsis protocol, get feedback from front-line clinicians, refine the protocol, conduct rigorous data gathering and analyze the results.

“It’s been a really amazing learning opportunity for me,” Johnson says. “It’s incredibly gratifying to me to see a patient who is so incredibly sick and follow the algorithm and see them a few days later and they are so much better.”

Before participating in improvement work, Johnson said that she didn’t see the reasons behind quality protocols, like the sepsis bundle that is used to treat sepsis within one hour.

“I think about it totally differently now,” she says. “I understand the reasons even if it feels arbitrary or clunky. When you see the results you see how worth it it is.”

Now a third-year resident, Johnson gave a presentation to first-year residents explaining the sepsis campaign and the sepsis bundle. She told the new residents that the goal is to identify patients with sepsis and get them the care they need quickly. This protocol is saving lives. CCRMC’s sepsis mortality rate has fallen steadily in the past five years, from 18% in 2010 to 6.4% in 2015.

Quality improvement training offers knowledge and confidence that Johnson will take with her as she moves through her career.

“It’s incredibly gratifying to see a patient who is so incredibly sick, follow the sepsis protocol, and then see the patient a few days later and they are so much better.”
APPROACHES TO TEST OR REFINE INTERVENTIONS

Plan-Do-Study-Act training for our DSRIP team members has been instrumental for testing and refining interventions.

CCRMC teams conduct PDSA cycles to test and refine changes to approaches. The PDSA cycle, which is part of the Institute for Healthcare Improvement’s Model for Improvement, is a simple but powerful tool. Essentially, teams “plan” the test; then they “do” the test by trying it in a real-world setting on a small scale; they then “study” results; and “act” to refine the change.

PDSAs are an integral step to producing change throughout our organization today. Hospital-acquired pressure ulcers (HAPUs) are a great example of our use of PDSAs to test and refine interventions. Five years ago, our HAPU prevalence rate was 2.39%. Our HAPU prevalence rate was at 0.44% this reporting year. The PDSAs were an essential tool in realizing this accomplishment, allowing us to gradually roll out evidence-based best practices in the identification, treatment and prevention of pressure ulcers.

HAPU identification, treatment and prevention must be woven into provider workflow. Today, our front-line clinicians conduct the Braden Score Assessment on all medical/surgical patients every shift to identify patients at risk for pressure ulcers. The “4 Eye Skin Assessment” — where two providers conduct and co-sign a skin assessment — is required on patient admission, post-operative, transfer and discharge to another facility. Additionally, our EHR “wound care tab” allows clinicians to document wounds and pressure ulcers in patient records. In May 2014, we began conducting daily admission audits to ensure every patient was being properly assessed.

This reporting period, our HAPU team began using preventative cushions for medical devices such as PEG or NG tubes. These cushions can help prevent pressure ulcers from forming around necessary medical devices. We also convened a task force to put a process in place around medical devices and pressure ulcers.

PLANS FOR SUSTAINABILITY

To make change sustainable, all of our staff — from leadership to managers to front-line staff — must pull together.

Our Access to Care Collaborative — aiming to improve access to our ambulatory care clinics — was a project with the Institute for Healthcare Improvement during the DSRIP. In this collaborative, we started with small tests of change at four clinics, with each clinic assigned a different project. Clinical support teams and nurse leaders were key team members, and received training on improvement principals. The teams met monthly with mentors from the IHI and in offsite learning sessions.

We found, however, that we were not providing enough on the ground improvement support for the clinical staff to be successful at each location, in addition to their daily work, to be sustainable for the long term. In response, CCRMC adjusted the model by consolidating all four tests at a single clinic, allowing all the tests to be conducted simultaneously with buy-in from all clinical support staff. This change resulted in (over a seven-month period) a drop in “third next available” appointments from 24 to eight days; an increase in patient continuity rates by 6% to 10%, and a reduction in the number of patients asked to return within four months by nearly nine points.

We learned a valuable lesson from this experience: To make change sustainable, all of our staff — from leadership to managers to front-line staff — must pull together.

Every three months through early 2016, we will roll out our new access to care model — developed and refined at the one test clinic — to one of our 11 ambulatory care clinics. We will adjust our approaches as necessary to achieve sustainable results.
Faith Hernandez has been a patient at Contra Costa Regional Medical Center and Health Centers since infancy. She was born at the medical center, as was her daughter and her granddaughter, and now visits the George and Cynthia Miller Wellness Center in Martinez for treatment for multiple health issues.

She suffered a stroke three years ago and was hospitalized for a week but has made almost a full recovery. She had a painful bunion on her foot removed that requires her to wear a soft cast until it heals. And she is currently in recovery for painkiller addiction. She takes four prescription medications, including one to control her high blood pressure.

She could easily end up in the emergency department or with a long hospital stay because of her multiple chronic conditions. She credits her primary care physician for keeping her on the right path.

“He is just the best,” she gushes. “He really takes care of me.”

At CCRMC and HCs, we are redesigning primary care to make it easier for patients to spend time with their preferred physician and get the care they need. An important DSRIP project is reorganizing care to put patients and families at the center.

For instance, in the past, sometimes Hernandez had trouble getting an appointment with her doctor or faced a long wait of two to three months to see him. Today, she typically gets an appointment within a week of calling. And hold times to talk to an appointment scheduler are also much shorter. “Now I only wait five minutes on the phone instead of 20 minutes,” she says.

Prior to her appointment, someone from the Miller Wellness Center calls her to make sure she will be there and to talk over the reason for her visit. “Come to think of it, before they would usually just leave a message,” she says.

Best of all, she says, if she runs out of her medication, all she has to do is call the health center and someone will call in a refill to her pharmacy that same day. She used to have to wait for refills.

Hernandez can receive care at other systems in the area, but she is very happy with her care at CCRMC and HCs. “I wouldn’t go anywhere else,” she says.
MODERNIZING
INTERPRETER SERVICES

Paloma Mahani sits in her office in Martinez armed with two tools of her work: a video console and a headset. Mahani is a Spanish medical interpreter at CCRMC and HCs. She has more than 20 years of experience, and just in the past few years began conducting interpretation over a secure video network.

Improving access to interpreter services and culturally competent care is an important DSRIP project. DSRIP funding allowed CCRMC and HCs to make the switch from in-person and telephone interpretation to video interpretation.

Today, interpreters work in a central location (in privacy protected individual offices) and conduct nearly all interpretation over a secure video and audio system. This allows interpreters to more than double the number of encounters per shift — from about 15 to 30 or more encounters.

Modernizing interpreter technology was necessary to join the Health Care Interpreter Network (HCIN), a not-for-profit consortium of about 20 safety net hospitals. This network gives patients and providers access to interpreters via video at any member hospital when our own interpreters are unavailable, improving access. At the same time, our interpreters pick up video calls from other member hospitals, reducing down time during shifts and related costs.

CCRMC and HCs provides culturally competent care to patients by hiring native speakers and thoroughly training new interpreters. Interpreters hail from El Salvador, Mexico, Bolivia, Nicaragua, Laos, China, Russia and Iran, among other nations.

A focus on cultural sensitivity and patient preferences has resulted in joint training among palliative care teams and interpreters to share understanding about cultural norms around pain, death and dying. Other hospitals around the country have adopted this training developed at CCRMC and HCs.

“It is in our hands to make sure we are accurate when we translate,” Mahani says. “We have to be extremely careful because we cannot make any mistakes with patients’ health.”

SYSTEM-LEVEL
CHANGES

DSRIP has been a powerful catalyst.

Leadership development, training in continuous improvement, implementing evidence-based best practices and modernizing our facilities and IT systems have all been possible because of the DSRIP.

As a community safety-net medical center, we are committed to making sure no one is left out or left behind. Equally important, we believe every member of our community deserves world-class health care. We do not want to be the provider of last resort, but the provider of choice for our community.

The leadership and oversight structure created for the DSRIP has been essential to ensure our success over the past five years. The DSRIP leadership team meets weekly to discuss milestone progress, resources and any issues that arise. This structure is scalable for other quality improvement projects. As a result, we have begun to use the leadership tools and oversight structure learned from the DSRIP to drive other quality improvement projects forward.

This reporting year, we unveiled a five-year strategic plan to take us through 2020. In May 2014, we assembled a broad planning team comprised of CCRMC staff and stakeholders, including patients and families. The team met in a series of work sessions, reviewing our systems, practices and approaches from top to bottom. Special workgroups studied specific areas and provided recommendations to the full planning team. All of this led to the creation of concrete priorities and key initiatives that will fundamentally direct CCRMC’s future decisions, resources and actions. A large measure of the success of this bold approach can be attributed to the leadership and team-based structure formed for the DSRIP.

Among the key considerations for the strategic plan were the rollout and implementation of the Affordable Care Act, the unprecedented growth in our health plan, as discussed previously, and uncompensated care payments, which are slated to be reduced starting in 2017. However, it was CCRMC’s broader vision of delivering optimal health to all that allowed us to reach beyond today’s realities and set a course that should effectively prepare us to address emerging and unforeseen challenges and opportunities.

To realize the ambitious goals of CCRMC’s strategic plan, three cross-functional teams will work together to drive our plan forward and ensure progress. These teams are comprised of the executive leadership; operations and front-line staff and are charged with working, thinking and leading differently than they have previously. We expect, however, our staff will use the same ingenuity and openness to new approaches garnered from five years of DSRIP work to make this happen.
We are eager to engage with other health systems, associations and quality improvement organizations to share our experiences, as well as see performance improvement in action.

On March 3, 2015, a delegation from CCRM C toured the newly renovated Hayward Wellness Center in neighboring Alameda County to share experiences on the medical home model. We were able to see design, workflow and patient experience changes that put patients at the center and support and reinforce a team-based, coordinated approach to care for the whole person. Subsequently, a delegation from Alameda County visited our Miller Wellness Center to witness our approach to patient-centered care and integration of behavioral health with primary care.

Additionally, our sepsis team contacted Kaiser Permanente Walnut Creek to study their protocol for serial lactates in sepsis cases. The team then presented these findings during the ED and inpatient sepsis meetings for discussion. Learning about protocols at other organizations helps us decide the best course of action within our own units.

Similarly, a member of the CLABSI team attended the Infusion Nursing Society (INS) annual conference in May 2015. That team member then presented to the group an overview of discussions and highlighted proposed changes to the Society’s guidelines. These guidelines will be published in early 2016.

Another nurse leader attended the Collaborative Alliance for Nursing Outcomes (CALNOC) conference on pressure ulcers, in October 2014 in San Diego, and shared trends and discussions on HAPUs with our internal teams. A VTE team representative attended a “Death by Clot” class at Stanford University Medical Center in March 2015 and shared key learning points with the team.

On June 3, 2015, our DSRIP manager and team members had the honor of presenting our results at America’s Essential Hospitals DSRIP Impact Webinar. Our presentation covered successes, challenges and lessons learned in key projects including HAPU, sepsis and ambulatory care redesign.

CCRMC has become a more innovative, efficient and sustainable part of our community’s health as a result of this investment and support.

CCRMC is pleased to present the milestone progress for our final year of California's first DSRIP. The bold vision and leadership of the Centers for Medicare and Medicaid Services (CMS), the state and California’s public hospitals throughout the last five years has presented new opportunities and ways of thinking that have significantly and permanently improved our patient care and overall performance. With the support of CMS and the Delivery System Reform Incentive Payment, we have introduced new approaches, new ways of thinking and new systems.

As shown in this report, those changes are literally saving lives, while dramatically improving patient experiences and inviting a new level of staff engagement and ownership. It is no overstatement to say the CCRM C has become a more innovative, efficient and sustainable part of our community’s health as a result of this investment and support. Throughout our drive toward continuous improvement, we have learned to leverage the power of a fully integrative health system that not only addresses clinical services, but also captures the power of Public Health approaches, Behavioral Health expertise and Contra Costa’s Health Plan. We look forward to working with our partners at the local, state and federal level on the next chapter in our shared journey towards optimal community health.