

# CIN

CONNECTIONS



Fall 2018 Issue:

## **Closing the Divide: Primary Care and Substance Use Disorder Treatment**

CALIFORNIA  
IMPROVEMENT NETWORK:  
*BETTER IDEAS  
for CARE DELIVERY*

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**A Reflection from  
CHCF President  
and CEO  
Sandra R. Hernández**



When I was a primary care internist at San Francisco General's HIV clinic, I had one patient I will never forget. He had been my patient for many years.

He had a history of intravenous drug use. One day he came to see me, and he was quite intoxicated. It wasn't clear if he had taken his methadone or not. He was barely ambulatory. I checked on his viral load and tested all of the things that good primary care physicians are trained to do. Eventually, we had a conversation about his drug use. I wanted to know what had motivated him to get on a bus and visit me on that day.

"Is there something else I can do for you?" I asked.  
"I never told you why I'm the way I am," he said.

He wasn't talking about his HIV. He was talking about his life. He then told me a profound story from his childhood growing up in El Paso, Texas. One day he was playing with his younger brother in a local waterway. The two of them were caught in a flash flood, and his brother died, and my patient had been carrying the guilt and suffering from that loss all his life. As a primary care physician, I immediately knew

that this story was the most important information I had ever heard from him. It helped me to see him as a whole human being, and that in turn allowed me to provide better care for him.

Patients like this one illustrate why CHCF is so focused on the integration of behavioral and medical care. How can we help health care providers to shed their vertical learning and look at individuals in their entirety to ensure they get the best care possible? At CHCF, we define behavioral health as the full range of mental and emotional well-being. This includes the treatment of mental illnesses like depression and personality disorders as well as substance use disorders and other addictive behaviors. It also includes how people cope with daily frustrations and challenges.

For too many Californians, behavioral health care is simply not there. Mental illness is one of the most common health challenges that Californians face. In 2014, 15% of California adults suffered from a mental illness, and two-thirds of them did not get treatment.

Treatment of chronic physical health issues for patients with behavioral health needs is also two to three times more costly than treatment for patients with only physical health needs.

**A Reflection from CHCF  
President and CEO  
Sandra R. Hernández**

“Is there something else I can do for you?” I asked. “I never told you why I’m the way I am,” he said. He wasn’t talking about his HIV. He was talking about his life.



Of the 5% of Medi-Cal enrollees who have the highest costs, 45% have a serious mental illness. That’s why behavioral health integration in which people receive coordinated or co-located care for all their health needs has such huge implications for Medi-Cal, California’s largest health insurance program.

Ensuring that Californians have timely access to mental health or substance use treatment — in a way that is culturally appropriate, evidence based, and linked to their physical health care — represents a huge challenge. But we are not daunted. Behavioral health conditions are eminently treatable. I believe that with smart investments in high-impact strategies, CHCF and the California Improvement Network can make meaningful contributions to encourage behavioral health integration.

In this issue of *CIN Connections*, you’ll learn strategies to engage patients in substance use disorder treatment, lessons on creating a true continuum of care for behavioral health, tips and tools for addressing behavioral health workforce challenges, and ways to get involved with CIN including webinars, grant opportunities, and other resources.

I applaud your efforts to advance this important work and look forward to hearing more about your ongoing achievements.

Sincerely,

A handwritten signature in black ink, appearing to read 'Sandra R. Hernández'.

**Sandra R. Hernández**

President and CEO  
California Health Care Foundation

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here.\*\*](#)

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## A Health Plan's Quest to Address Substance Use Disorders and Lower Costs

Speaker:

**Robert Moore, MD, MPH, MBA**

Chief Medical Officer

Partnership HealthPlan of California (PHC)

The impact of substance use disorders (SUDs) on total cost of care is significant. It is one of PHC's top three cost drivers. In 2017 alone, a quarter of PHC's covered hospital costs — \$178 million — was spent on providing care to members whose primary or secondary diagnosis was of SUD. Knowing the tremendous implications, and encouraged by efforts at Kaiser Permanente South Sacramento that demonstrated savings of \$1.44 for every \$1 spent on integrated medical, behavioral, and SUD care, leaders at PHC have launched several SUD integration strategies to improve care and quality of life for the plan's members. Robert Moore, MD, MPH, MBA, chief medical officer of PHC, shared highlights of their current efforts at the September 28 partner meeting.

### The health plan as the SUD treatment provider

Recognizing that options for members with SUDs are extremely limited in their region, PHC has set out to become an administrator of traditional SUD treatment. They are currently negotiating with the California Department of Health Care Services to become the first Medi-Cal managed care plan in California to offer SUD services and to create a service model that would include outpatient and residential treatment and establish opioid treatment centers.

### Address social needs tied to SUD

Historically, social support programs have provided housing only after SUDs have been treated, a policy that has proven ineffective.



In 2017 alone, a quarter of PHC's covered hospital costs — \$178 million — was spent on providing care to members whose primary or secondary diagnosis was of SUD.

## A Health Plan's Quest to Address Substance Use Disorders and Lower Costs

More promising models emphasize “housing first,” where housing is provided along with additional social support services, and these programs are resulting in greater success in lowering substance use rates. This information, combined with PHC’s data showing that their

members who were homeless also accounted for a significant portion of inpatient costs, has driven the organization’s recent \$25 million investment to address homelessness for members in the region.

### Support primary care providers in providing SUD services

PHC is supporting the integration of SUD services into primary care and other settings by paying for SUD services provided by primary care and mental health providers; this includes medication-assisted treatment (MAT) and alcohol withdrawal management in the primary care setting as well as counseling. PHC also supports a number of other initiatives designed to improve the care and lives of those with SUDs, including using its [Managing Pain Safely](#) initiative to reduce the number of members who become addicted to opioids, and supporting innovative community-based programs for high-risk individuals such as [Petaluma Sober Circle](#) and [La Clinica Vallejo’s Transition Clinic](#).



Robert Moore, MD, MPH, MBA, chief medical officer, Partnership HealthPlan, and CIN managing partner, raises a question.

## Five Tips to Engage Patients in Substance Use Disorder Treatment

Speaker:

**Candy Stockton, MD**  
Physician, Humboldt IPA

Candy Stockton, MD, first became interested in substance use disorders (SUDs) as a medical director at Shingletown Medical Center. The majority of her patients there lived in poverty, and many faced alcoholism in addition to opioid addiction. Stockton set up a judgement-free zone at the health center and offered some of the earliest medication-assisted treatment (MAT) in Shasta County.

Along the way, Stockton learned about adverse childhood experiences, which explained a concept she had observed and had been trying to articulate for several years: Traumatic experiences during childhood are common in families with SUD problems and have long-term consequences for their overall health. She became passionate about the idea that health care providers could change the future for children if they could better address addiction in families.

Since then, Stockton has gained a decade of experience treating and running programs related to SUDs. She is currently a physician at CIN partner organization Humboldt IPA. Below are her five tips for engaging patients in SUD treatment:

A person struggling with addiction or a SUD is not an “addict,” “drug abuser,” or “user.” Drug tests should not result in “clean” and “dirty.”



### **Humanize patients with the words you use.**

A person struggling with addiction or a SUD is not an “addict,” “drug abuser,” or “user.” Drug tests should not result in “clean” and “dirty.” Providers can’t carefully guard what they say to their patients and then talk disrespectfully about patients with staff.

## Five Tips to Engage Patients in Substance Use Disorder Treatment

It's time to change health providers' mind-sets so that they view addiction as a chronic disease that can exist in patients indefinitely. Like diabetes, addiction is a disease that will be easier or more challenging to control depending on patients' life circumstances.

2

### Use a chronic disease model.

Like diabetes, addiction is a chronic disease, so provider should use the same approach

to treat it. For example, consider a provider who has a patient with Type 2 diabetes. That patient has been hospitalized and has a very high A1C of 14. She lost her job because she had too many sick days, and she has not sought medical care for five years. If a physician told that patient: "You're not serious about getting better, come back when you are serious," that physician could get sued for malpractice. If the doctor said to her: "I'll prescribe insulin for your diabetes, but only if you agree to go to diabetes education for the next six weeks," that could be equally problematic.

Much addiction treatment has been based around an abstinence-only "one strike and you're out" model. It's time to change health leaders' mind-sets so that they view addiction as a chronic disease that can exist in patients indefinitely. Like diabetes, addiction is a disease that will be easier or more challenging to control depending on patients' life circumstances. It is not the provider's job to shame their patients, but rather to support patients in their recovery.

3

### Model the attitude patients deserve.

Parents don't have to be perfect in order for their kids to turn out all right, and

addiction treatment is similar. Caring and trying will carry health care providers through many of the mishaps and mistakes that will happen along the way and help them engage patients effectively. Among other things, it is important to remember that everybody dealing with addiction is somebody's child who is loved and important.

4

### Train staff.

Providers who are excited about SUD treatment should train their staff members.

Health care organizations can't implement successful treatment programs without having all staff members on board at every level, including medical assistants and receptionists.

5

### Check judgement and recognize internal biases.

Staff members' attitudes toward and stereotypes about people with SUDs can poison a program. Does a care team member have a family member with an SUD who stole from them or broke their trust? Does a provider view MAT

## Five Tips to Engage Patients in Substance Use Disorder Treatment

Staff members' attitudes toward and stereotypes about people with SUDs can creep through and poison a program. Effectively engaging patients with SUDs involves every member of the care team.

as enabling patients to get high but just with a different drug? Do physicians complain about patients with staff members? Attitude is reflected in interaction with patients. The first step is acknowledging internal biases and then creating a shift that will eventually spread throughout organizations and communities.

**Want more tips & tools related to SUDs? [Register now for a webinar featuring Stockton.](#)**

Participants will:

- Gain awareness of various approaches to alcohol use treatment including MAT
- Learn how to effectively promote MAT services to providers

FROM CHCF'S CALIFORNIA HEALTH CARE ALMANAC:

**“Substance use disorders (SUDs) are common. About 8% of Californians met criteria for SUD, but only 10% of people with a SUD received any type of treatment.”**

### Prevalence of Substance Use Disorder, by Drug Type California, Annual Average, 2015 to 2016

Percentage of population age 12 and over with this type of substance disorder

Any Substance



Population (in Thousands)

2,757

Alcohol



2,088

Illicit Drugs



1,068

Pain Medication



206

Notes: *Illicit drugs* includes marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, methamphetamine, and nonmedical use of prescription drugs. *Pain medication* is referred to as pain reliever in the survey and is defined as use in any way not directed by a doctor.

(Source: California Health Care Foundation's Health Care Almanac, [Substance Use in California: A Look at Addiction and Treatment](#))



## Electronic Screening, Brief Intervention, and Referral

Speakers:

**Jorge Fernandez, LCSW**

Director of Behavioral Health  
Golden Valley Health Centers

**Ellen Piernot, MD, MBA**

Chief Medical Officer  
Golden Valley Health Centers

**C**IN partner organization Golden Valley Health Centers, a federally qualified health center with facilities throughout California's Central Valley, has been developing its tools

and workflows for screening and treatment of its patients' behavioral health needs for the past five years. After having started with using standard screening surveys on paper for depression, anxiety, alcohol, and other drug use, Golden Valley now has a digital system for screening, brief intervention, referral, and treatment (SBIRT) for alcohol and other drug use in place in three pilot clinics. Staff members at these clinics are able to capture screening data electronically and then use diagnostic codes to track patients' treatment needs, referrals, and status.

### "The iPad was the tipping point"

SBIRT at the three pilot clinics uses screening questionnaires administered on tablets to collect survey responses from patients; the clinic's staff members find that patients are more comfortable answering these questions on a screen than discussing them in person. As Chief Medical Officer Ellen Piernot, MD, MBA, said, "The iPad was the tipping point because

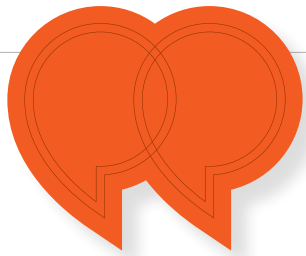
it made the survey private from staff, who may be our patient's neighbor in our small community." Additionally, the use of tablets to complete SBIRT screening forms while patients are waiting to be seen by providers makes the screening process more efficient, as it minimizes the work of the medical assistants in the electronic health record (EHR).

The screening tools themselves have also changed. Golden Valley now uses the following: Alcohol Use Disorders Identification Test for alcohol, the Drug Abuse Screening Test for other drugs, and the CRAFFT screening interview tool for adolescents. Golden Valley prioritizes these screenings for any patient scoring high on the Patient Health Questionnaire (PHQ-9) for signs of depression or for risky or harmful use of alcohol and other drugs. Screening rates across provider care teams are used to generate friendly competition among staff members, particularly medical assistants, who are primarily responsible for the completion of annual surveys.

### Warm handoffs, integrated interventions

When clinic staff members identify a need for behavioral health services screenings, they attempt a warm handoff to the clinic's

## Electronic Screening, Brief Intervention, and Referral



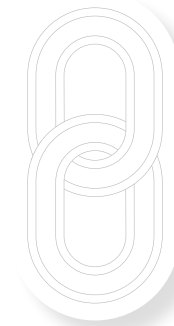
The iPad was the tipping point because it made the survey private from staff, who may be our patient's neighbor in our small community."

Ellen Piernot, MD, MBA  
Chief Medical Officer  
Golden Valley Health Center

co-located behavioral health staff. Health educators, recovery services specialists (certified drug and alcohol counselors), nurses, and staff from the Comprehensive Perinatal Services Program have been trained to provide brief interventions to OB/GYN patients. If a brief intervention is not possible on the same day, medical assistants can enlist the SBIRT task group identified in the EHR, which includes all staff trained on doing brief interventions. This way a return appointment is made to bring patients back for full diagnostic interviews, treatment, and if needed, referrals to higher-level specialty care services. Golden Valley is considering using telehealth as a format for the brief behavioral health intervention when onsite staff aren't available.

### Next steps for Golden Valley Health Centers

The process developed in these three clinics is being rolled out this year to other clinic sites, three at a time every two weeks. Future plans for SBIRT at Golden Valley include a digital version of the survey that can be administered via patients' smartphones and engaging other departments like health education and perinatal services in the work of screening and treatment.



For more resources and information on substance use disorder treatment and integration, visit the [CIN Resource Page](#), which contains a list of tools and articles for you to leverage at your own organization.

## How San Francisco Health Network Is Integrating Substance Use Disorder Care

Speakers:

**Radawn Alcorn, MSW, LCSW**

Director of Integrated Primary Care Behavioral Health  
San Francisco Health Network

**Judy Martin, MD**

Deputy Medical Director,  
Behavioral Health Services  
Medical Director,  
Substance Use Services  
San Francisco Health Network

A

s the need to better integrate substance use disorder services into primary and other care settings persists, how can separate departments identify

shared priorities and work together? That's what two San Francisco Health Network (SFHN) leaders, Radawn Alcorn, MSW, LCSW, director of integrated primary care behavioral health, and Judith Martin, MD, deputy medical director for behavioral health services and medical director for SUD services, explored in an intimate and candid conversation with CIN partners at the most recent partner meeting.

Currently, care integration between primary care and behavioral health in the SFHN system includes behavioral health clinician staff at all 14 primary care centers in the network supported by coordinator-level behavioral health assistants who help patients with social service needs. These behavioral health staff members support patients as part of the clinic care team. Psychiatrists from the county's specialty mental health clinics attend in the primary care clinics as consultants. Behavioral health specialists document care in the primary care clinic's electronic health record system while checking the separate electronic records

system used by the behavioral health clinics. They ask patients to sign records release forms, which allows for more streamlined sharing of information and more integrated care.

Martin and Alcorn shared how primary care services have been added to four existing mental health clinics. Alcorn said, "It was the right thing to do. People were showing up in mental health clinics, and they needed other care." Three mental health clinics partnered with nearby SFHN primary care centers to place staff in the mental health center. The fourth added a nurse practitioner to its staff to provide for medical needs.

### Medication-assisted treatment

To address opioid addiction, all SFHN psychiatrists are trained in medication-assisted treatment (MAT) and prescribe MAT medications. Primary care providers also prescribe MAT medications as well as psychiatric medications and nicotine replacement therapy. SFHN takes advantage of ideal times to start patients on MAT, including while they're in jail. San Francisco also has a specialty clinic for opioid addiction treatment that operates an induction clinic; patients are able to start MAT and stabilize, after which their care is transitioned back to primary care.

## How San Francisco Health Network Is Integrating Substance Use Disorder Care



San Francisco Health Network's Judy Martin, MD, deputy medical director, behavioral health services, and Radawn Alcorn, MSW, LCSW, director of primary care, behavioral health, discuss SFHN's efforts to integrate behavioral health services.

### Next steps and challenges

As Martin and Alcorn consider next steps for their work together, they focus naturally on what challenges are most pressing and how the two of them might prioritize and address some of those issues together. Many challenges for providing integrated care fall under the

familiar category of communication between providers, separate programs, and electronic record systems. Service funding itself reinforces barriers.

In addition, providers and staff learn how to deliver integrated care through cross-training across specialties in standing meetings and in specific best practices like motivational interviewing. UCSF and SFHN partner on an annual Pain Day conference where providers share best practices in pain treatment and the services available for patients such as group visits and individual talk therapy. Martin and Alcorn agreed that staff education is an area for constant development. One possibility is to better leverage existing meetings and trainings to surface issues and identify creative solutions.

Although they face challenges, Alcorn and Martin will continue to work together to provide the best SUD care possible to San Franciscans.

### Physicians Waivered to Prescribe Buprenorphine

California, 2002 to 2018



(Source: California Health Care Foundation's Health Care Almanac, *Substance Use in California: A Look at Addiction and Treatment*)

## State of the State: Strengthening California's Mental Health Workforce

Speaker:

**Sunita Mutha, MD, FACP**

Director, Healthforce Center at UCSF

While access to public and private insurance coverage for behavioral health services has improved substantially over the past two

decades, many Californians with mental illness or substance use disorders (SUDs) do not receive treatment. [Healthforce and CHCF research](#) indicates that if current trends continue, California will have 41% fewer psychiatrists than needed and 11% fewer psychologists, licensed marriage and family therapists, licensed professional clinical counselors, and licensed clinical social workers than needed by 2028. To improve access and quality, California needs an adequate supply of behavioral health workers who are distributed equitably across the state and who reflect the demographic characteristics of the state's population.

Sunita Mutha, MD, FACP, director of Healthforce Center at UCSF, presented data on the state of the mental health workforce at the CIN fall partner meeting. These data are critical for understanding the issues related to behavioral health care and the variability across the state. Creative solutions, such as using telehealth to extend expertise across geographic regions

and using community health workers, peer providers, and members of other emerging professions, can help meet today's needs while planning for the long term.

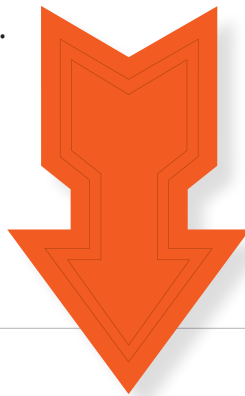
### **CIN partners react to behavioral health workforce shortages**

The CIN partners had a robust conversation with questions and comments regarding the state of the behavioral health workforce. Below are a few highlights:

- For many partners, these data are new, and they are more severe than expected. Though there is an awareness of shortages, the extent and severity of the shortages across the state were far greater than the group had anticipated; for instance, many organizations reported struggling to fill vacancies for behavioral health roles. Having these data for reference will help partners in their planning efforts.
- Partners discussed how they might get creative in order to adapt to shortages while still meeting patient needs. One partner is exploring group treatment models combined with telehealth, where the provider is on video teleconference and the patient group is together in a

## State of the State: Strengthening California's Mental Health Workforce

California will have 41% fewer psychiatrists than needed and 11% fewer psychologists, licensed marriage and family therapists, licensed professional clinical counselors, and licensed clinical social workers than needed by 2028.



room. Another is wondering how the organization might leverage mental health support structures and resources that exist outside the health care system such as faith organizations, and another is considering how successful models that use barber shop and nail salon interventions to help address hypertension and other

chronic conditions could be adapted to behavioral health.

- Adapt and persist was the theme for many partners, who are doing the best they can in spite of these shortages by partnering with community groups and experimenting with new models of care.

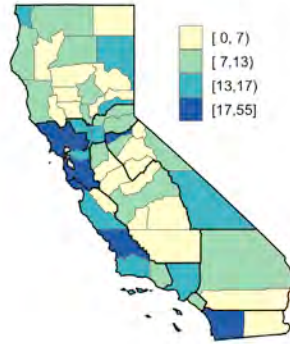


Sunita Mutha, MD, FACP, director, Healthforce Center at UCSF and CIN managing partner, provides an overview of California's mental health workforce.

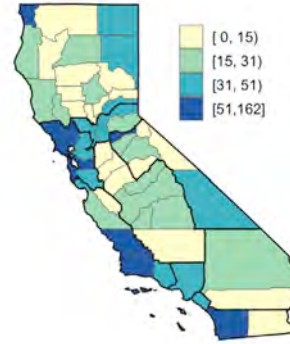
## Ratios of Behavioral Health Professionals per 100,000 Population by County, 2016

### State of the State: Strengthening California's Mental Health Workforce

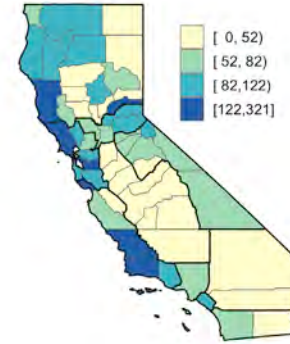
Psychiatrist



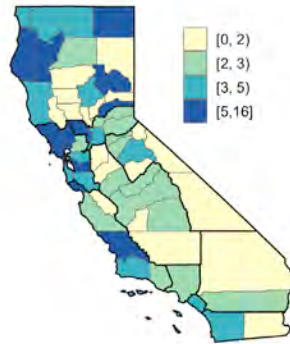
Psychologist



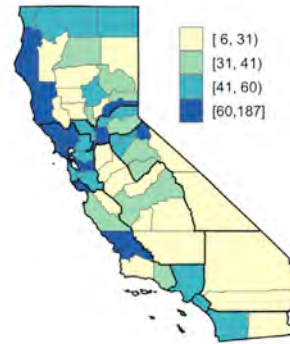
Marriage & Family Therapist



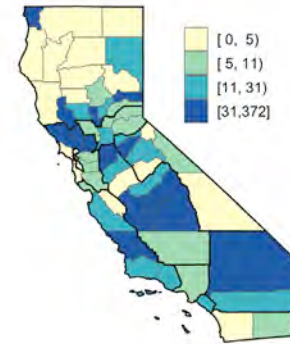
Licensed Professional  
Clinical Counselor



Licensed Clinical  
Social Worker



Psychiatric Technician



(Source: Coffman et al. California's Current and Future Behavioral Health Workforce, February 2018)



What are your organization's behavioral health workforce needs? How are you changing your models or approaches to compensate for shortages? Or, are shortages not an issue in your area? We'd love to hear from you. Contact us at [CIN@UCSF.edu](mailto:CIN@UCSF.edu).

## Announcing CIN's Behavioral Health Integration Action Project



Samira Pingali, behavioral health network manager, Community Health Center Network, provides CIN partners an update on the behavioral health integration action group.

A critical aspect of providing high-quality, integrated behavioral health care is ensuring integrated treatment for patients with substance use disorders (SUDs). CIN partner organizations of all types are encountering significant challenges in providing high-quality, cost-effective SUD care for patients.

Care teams need to be better equipped with the knowledge of what SUD services they can offer and how best to deliver those services, comfort with and confidence in providing high-quality SUD-related care, and a willingness to provide SUD-related services.

The CIN behavioral health integration action group is a working group of improvement leaders from phase 6 partner organizations who have joined together to collaboratively improve care and outcomes for patients with

SUDs. The group aims to better understand what makes care teams ill-equipped to provide SUD services. Over the next several months, this action group will:

- Identify proven strategies for equipping care teams with the knowledge, comfort, and willingness to provide effective, integrated SUD services in the primary care setting.
- Identify organizations in the field that are doing this work well and determine how others can learn from them.
- Provide actionable guidance to organizations seeking to better support their care teams and overcome this challenge.

**Look for a CIN toolkit to be published in January 2019 along with a webinar to share findings and strategies related to this work at [chcf.org/cin](http://chcf.org/cin).**



**Interested in joining the CIN behavioral health integration action group and contributing to this project?**

Email [CIN@ucsf.edu](mailto:CIN@ucsf.edu) to find out more!



## CIN Partners Make Progress in Addressing Social Needs That Impact Health

Since the spring partner meeting on addressing social needs that affect health with an emphasis on cost management, CIN partners have been busy taking action on this issue. Below are a few highlights of the inspiring work they've done to reduce disparities and think beyond the exam room in tackling social influences on health.

### California Quality Collaborative – Statewide



“The California Quality Collaborative has incorporated social needs evidence and resources into our four-year strategic planning process and are developing a goal around this area. We expect a body of work to revolve around addressing social needs within the delivery system. We are exploring a pilot for social needs financing and allocation with a partner organization. We understand that social needs shouldn't be a separate goal and it should run across everything we do.”

**April Watson, MPH**, director, practice transformation, California Quality Collaborative

### Golden Valley Health Centers – Central Valley



“We have had a meeting to discuss how to include widespread capture of social needs. Additionally, we have made changes in several of our electronic health record templates to more accurately capture this information. We continue to work

with partners on several fronts: We're addressing homelessness through a countywide initiative to develop a low-barrier shelter with co-located social services. We have expanded our street nursing program. We've partnered with several food agencies to do outreach during our health center events...and more!

**Ellen Piernot, MD, MBA**, chief medical officer, Golden Valley Health Centers

### Community Clinic Association of Los Angeles (CCALAC) – Los Angeles



“We are in the process of securing grant funding so we can hire a health equity manager who will help us coordinate efforts both internally for CCALAC as

well as assess the level our members are engaged in social needs work. We would like to see more regional coordination of activities and bring together clinic staff to share tools, resources, and best practices and build more infrastructure so that these networks can collaborate more efficiently and effectively.”

**Matt Moyer, MPH**, director of clinical services, CCALAC

## Get Involved and Join Us

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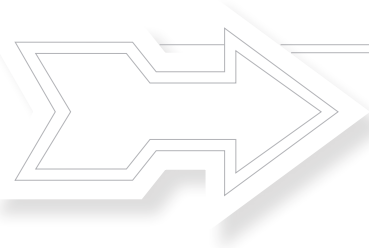


Amanda Clarke, MPH, associate director of programs, California Health Care Safety Net Institute, right, chats with Giovanna Giulliani, MBA, MPH, executive director, California Health Care Safety Net Institute.

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CIN CONNECTIONS  
Fall 2018  
[chcf.org/cin](http://chcf.org/cin)

Join us for upcoming technical assistance opportunities!



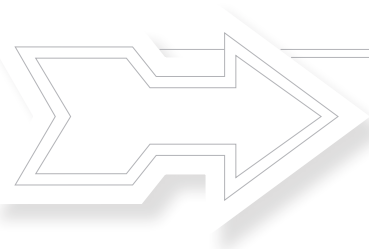
**REGISTER NOW: CIN Webinar**

Engaging Providers in Substance Use Disorder Treatment (SUD)

**October 23, 2018 ■ 12–1:00PM (PT)**

This webinar is for all types of health organizations that are working on integrating SUD treatment services into primary care. Participants will:

- Gain awareness of various approaches to alcohol use treatment and medication-assisted treatment (MAT)
- Learn how to effectively promote MAT services to providers



**APPLY: Request for Proposals**

Social Needs Screening and Referral Workflows

**Proposals due by October 26, 2018**

Help spread effective practices in addressing social needs. The grantee for this project will explore, record, and share examples of implementation efforts related to screening and referral for social needs from leading health organizations. Apply by Oct. 26, 2018.

California  
Improvement  
Network Better Ideas  
for Care Delivery



Healthforce  
Center at UCSF

CIN is a project of the California Health Care Foundation and is managed by Healthforce Center at UCSF.

## Join Us

[Sign up  
here.](#)

Learn more and stay apprised of quality improvement resources, events, and opportunities for engagement offered through CIN.

Have you tested out any of the quality improvement recommendations or tools included in this issue? Tell us how it went. We are here to answer your questions or connect you to additional resources. Email us at [CIN@ucsf.edu](mailto:CIN@ucsf.edu).

## Contact Us

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