CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)

* **DPH SYSTEM:**	Alameda County Medical Center
* **REPORTING YEAR:**	DY 7
* **DATE OF SUBMISSION:**	9/29/2012

Total Payment Amount

This table sums the eligible incentive funding amounts. Please see the following pages for the specifics.

* Instructions for DPH systems: Please input the DPH System Name, Reporting DY & Date. Everything else on this tab will automatically populate.

Category 1 Projects - Incentive Funding Amounts	
Expand Primary Care Capacity	$ 4,899,750.00
Increase Training of Primary Care Workforce	
Implement and Utilize Disease Management Registry Functionality	$ 3,062,343.75
Enhance Interpretation Services and Culturally Competent Care	
Collect Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities	
Enhance Urgent Medical Advice	
Introduce Telemedicine	
Enhance Coding and Documentation for Quality Data	
Develop Risk Stratification Capabilities/Functionalities	
Expand Specialty Care Capacity	$ 3,062,343.75
Enhance Performance Improvement and Reporting Capacity	$ 1,633,250.00
TOTAL CATEGORY 1 INCENTIVE PAYMENT:	$ 12,657,687.50
Category 2 Projects	
Expand Medical Homes	$ 3,920,000.00
Expand Chronic Care Management Models	$ 3,920,000.00
Redesign Primary Care	
Redesign to Improve Patient Experience	$ 3,920,000.00
Redesign for Cost Containment	
Integrate Physical and Behavioral Health Care	
Increase Specialty Care Access/Redesign Referral Process	
Establish/Expand a Patient Care Navigation Program	
Apply Process Improvement Methodology to Improve Quality/Efficiency	
Improve Patient Flow in the Emergency Department/Rapid Medical Evaluation	$ 3,920,000.00
Use Palliative Care Programs	
Conduct Medication Management	
Implement/Expand Care Transitions Programs	$ -
Implement Real-Time Hospital-Acquired Infections (HAIs) System	
TOTAL CATEGORY 2 INCENTIVE PAYMENT:	$ 15,680,000.00
Category 3 Domains	
Patient/Care Giver Experience *(required)*	$ -
Care Coordination *(required)*	$ 3,324,750.00
Preventive Health *(required)*	$ 3,324,750.00
At-Risk Populations *(required)*	$ 3,324,750.00
TOTAL CATEGORY 3 INCENTIVE PAYMENT:	$ 9,974,250.00
Category 4 Interventions	
Severe Sepsis Detection and Management *(required)*	$ 937,750.00
Central Line Associated Blood Stream Infection Prevention *(required)*	$ 234,437.50
Surgical Site Infection Prevention	$ 1,406,625.00
Hospital-Acquired Pressure Ulcer Prevention	$ 468,875.00
Stroke Management	
Venous Thromboembolism (VTE) Prevention and Treatment	
Falls with Injury Prevention	
TOTAL CATEGORY 4 INCENTIVE PAYMENT:	$ 3,047,687.50
TOTAL INCENTIVE PAYMENT	$ 41,359,625.00

Category 2: Expand Chronic Care Management Models

Process Milestone:	Develop business plan to expand the care management model beyond chronic hepatitis and chronic pain to include care of complex patients (e.g., homeless, mentally ill, and patients with multiple chronic medical illnesses) requiring care coordination and interdisciplinary care resources. Metric: Documentation of plan, including staffing model, budget, space and scheduling logistics.

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	
Denominator (if absolute number, enter "1")	
Achievement	Yes
If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:	Yes

Results: The business plan to expand the care management model beyond chronic hepatitis and chronic pain to include care of complex patients (e.g., homeless, mentally ill, and patients with multiple chronic medical illnesses) requiring care coordination and interdisciplinary care resources (HOPE Center) was completed and approved.

The plan includes a detailed business case justification, as well as a review of national models for complex care, a staffing model, and a plan for space and budget. An analysis of patient census and clinic flow estimates, staffing model with salaries, clinic expenses, return on investment (ROI) calculations, and theoretical modeling for cost savings was completed. The ROI is based on the modeling work by John Billings and Tod Mijanovitch.

Key details from the HOPE Center plan:
Mission: To improve the care of ACMC's most complex and vulnerable patients by replacing episodic high-cost interventions with longitudinal intensive outpatient care.
Vision: Through increased emphasis on care coordination and service integration for our system's sickest patients the HOPE Center can achieve:
• Reduced system costs by increased efficiency of care for complex patients
• Improved health outcomes for our most vulnerable patients
• Improved clinic flow and decreased congestion in outpatient clinics
Objectives:
• Identify patients at risk of highest cost and redundant care in the ACMC patient population
• Recruit 200 patients by end of FY2013, 400 patients by end of 2014 through a tiered process of selection combining case identification through data and physician referral
• Establish care model including interdisciplinary teams, personal care plans, care coordination, behavioral health integration, open access to and continuity of care
• Demonstrate improved processes by measurement of baseline and intervention patient data for hospitalization rates and ED utilization rates as well as other direct health markers
• Incorporate new funding mechanisms and federal and state incentives programs for care of high-risk populations to ensure continued sustainability of plan

The HOPE center model of care was developed by a steering committee over the course of many meetings starting in the fall of 2010. The HOPE steering committee included doctors, planners, nurses, administrators, a pharmacist, nutritionist, and comprised representatives from ambulatory services, quality, inpatient service, psychiatry, and hospital administration. The services of a half-time intern starting in September 2011 accelerated the progress of planning significantly.

The first planning phase included comprehensive literature reviews, informational interviews with leaders in the field of chronic and complex care, key stakeholder interviews within ACMC, monthly presentation of research findings at HOPE Center Steering committee meetings, and steering committee consensus-building for key features to incorporate into the HOPE model. Three sub-committees met to design specific components of the clinic (patient selection, staffing model, space). The vision and model are described in a written paper produced at the end of phase I.

With this work completed, the HOPE committee requested funds to hire a medical director and program administrator to begin the implementation and to finalize the details of the model and staffing structure. The proposal was approved by the DSRIP Oversight Committee, and the staff was hired and began work in June 2012. They have been developing plans for the opening of the HOPE center in October 2012. A space for the center was identified and a contract for construction and renovation of the space was secured.

A HOPE Center colloquium (or "Charrette") was held in June; this was a regional meeting designed to bring together ACMC's internal planning group with external community stakeholders and national experts to gather input on specific design questions for the complex care center. The Charrette was attended by about 30 people, including experts from Stanford, UCSF, and Denver Health; internal stakeholders from ACMC and community representatives from, e.g.,

Category 2: Expand Chronic Care Management Models

Healthcare for the Homeless, UC School of Social Welfare, senior services, and housing and mental health programs. A grant from the California HealthCare Foundation funded the event.

The basic business rationale for the “ambulatory ICU” model is that the intensive and costly services model will result in avoidance of high cost utilization such as ED visits and inpatient admissions. One of the challenges for sustainability of the complex care clinic over time is that question of what entity gets the benefit of the savings. Depending on who is bearing the expense, cost avoidance could benefit ACMC, or it could benefit the payer. In the latter case, ACMC would approach our MediCal managed care provider, the Alameda Alliance for Health, about sharing the costs in order to make maintaining the program feasible.

We will draw on both internal resources and connections with local academic institutions for staff training. A member of the department of internal medicine at ACMC will provide training on motivational interviewing, a key skill for staff. Stanford University School of Medicine’s "Coordinated Care" clinic, has agreed to provide additional training for staff.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	yes
Achievement Value	1.00

Category 4: Central Line Associated Blood Stream Infection (CLABSI) (required)

One focus of the team has been to revise CLABSI policy in accordance with CDC guidelines. The change in policy was communicated to staff through morning huddles and manager feedback to staff. The CLABSI team identified the need to streamline the process of approval and education regarding the implementation of changes to policy and procedures.

Staffing changes have helped to maintain CLABSI-related projects and to support the harm reduction team in achieving our milestones. The recent hiring of a project assistant and a critical care outcomes nurse coordinator who is an expert in central lines provided increased capacity for monitoring and maintaining best practices. In addition, the in-house PICC line nurse team has expanded from 1 to 3 permanent nurses, greatly supporting the medical center's continued efforts in reducing CLABSI events.

Some of the education and improvement activities that are supported by this expanded team include:
• In order to increase the use of CLIP forms for all central line patients, the CLIP form has been attached to all line kits. The frequency of cart restocking has increased, and monthly audits of IV tubing maintenance have begun.
• Through role-modeling by attending physicians in the ICU, junior medical staff has been fully engaged in the completion of CLIP forms and adoption of the CLIP standards in the medical center. This role-modeling contributes to sustaining and embedding CLIP.
• In June, a targeted re-education program for inpatient nurses was piloted through in-service education to inpatient nurses regarding care of central lines. An open invitation for people to attend a class on declotting procedure was sent to all inpatient nursing staff and based on positive feedback, the class will be repeated.
By using data, we engage staff in best practices to maintain low CLABSI rates. We regularly present CLABSI rates to staff using graphs and tables on notice and bulletin boards, while also reinforcing good practice and outlining opportunities for improvement. Quality analysts are working to create a more efficient and transparent monthly hospital report on CLABSI as well. The barriers that the CLABSI harm reduction team has faced are largely related to staff and physician support. We have had a strong physician champion for CLABSI and Sepsis, but she has taken on other responsibilities, so we are seeking a new physician champion. We are continuing to examine and test how staff roles can best be organized to support best practices regarding central lines.

Another challenge has been collection of data in the Emergency Department, as compared to the inpatient floors. There are two reasons for this: First, the ED has its own data system, and the CLIP form is embedded in that system. The CLABSI team does not have the ability to easily access this information. Secondly, a significant number of central line insertions occur in trauma cases and the collection of data is challenging due to the pace of the procedure and care given.

In 2013, the ED is scheduled to move to the same comprehensive EHR that will be used in the inpatient setting, enabling us to collect data in a more standardized fashion. In the meantime, the CLABSI nurse lead has reached out to the Trauma services and they plan to conduct an exploratory review of charts for 10% of the emergently inserted lines.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	yes
Achievement Value	1.00

Optional Milestone: Report at least 6 months of data collection on CLIP to SNI for purposes of establishing the baseline and setting benchmarks
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	231.00
Denominator (if absolute number, enter "1")	233.00
Achievement	0.99
If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:	Yes

ACMC CLIP Compliance Baseline (CY2010) is 99.14%.
Numerator = # completed CLIP Forms; denominator = total # CLIP Forms
ACMC expanded our baseline from 6 to 12 months and reported 12 months of CLIP compliance data to SNI on June 26, 2012. Our baseline data is from Calendar Year 2010 (1/1/2010 - 12/31/2010) as it was reported to National Healthcare Safety Network (NHSN).

In-depth description of milestone progress is included in the previous box.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	yes
Achievement Value	1.00

Category 4: Hospital-Acquired Pressure Ulcer Prevention

Optional Milestone: Share data, promising practices, and findings with SNI to foster shared learning and benchmarking across the California public hospitals.
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	
Denominator (if absolute number, enter "1")	
Achievement	Yes
If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:	Yes

At the same time that ACMC became a full CALNOC member in December 2011, Cal NOC changed the parameters for the pressure survey to include sub-acute sites; ACMC has not yet added our skilled nursing facility or rehabilitation sites to the survey, but we will do so starting in the fourth quarter of calendar year 2012.

The second half of DY7 was a challenging time for our quality program, yet it was also a time of significant changes that we anticipate will enable us to reach the target improvements in HAPU for this year and the future.

During this period, under the leadership of our new Vice President of Quality, who began in August 2011, there was a significant reorganization of the Quality Department. A combination of retirements and pre-existing vacancies had resulted in an under-staffed department. This presented the opportunity to re-build the department, transforming it from an old-school quality assurance department to a performance improvement system, better able to support ACMC in achieving a new level of quality as we enter into a new era under health care reform.

In April of 2012, two new leaders were hired, the Director of Quality and Performance Improvement and the Director of Accreditation, Risk Management and Patient Safety. An epidemiologist with a higher level of training and experience than previous staff joined the team in May as a quality analyst.

Although there was a HAPU harm reduction team active in the prior year that piloted many improvements, many of the changes were not sustained. One of the activities of the new Quality team has been to re-establish harm reduction teams, setting new SMART objectives for phase II. A new nurse leader will be assigned to work with the team.

Some of the HAPU team's phase II objectives are aimed at embedding phase I improvements so as to get the impact that we intended. For instance, one of the team objectives is to develop protocols and trainings for utilization of new equipment (e.g., mattresses, chairs, commodes) by December 31, 2012, and to implement those trainings by December 31, 2013.

As another of their early activities, the new Quality team made a complete in-depth assessment of the care system related to HAPU. Two major issues were found: inadequate staffing for wound assessment, and an inadequate data system for tracking and communicating about pressure ulcers. The team concluded that a full-fledged reorganization of the wound care system is needed in order to make and sustain improvements in outcomes. With the support of the executive team, this reorganization will be planned in the coming months.

Currently ACMC has only one certified wound care nurse specialist who is expected to cover two campuses. A position for a new half-time nurse practitioner has been created and will be added to the wound team. The quality team will map the flow of wound care work with the wound specialists and the harm reduction team to re-organize the process. In addition, policies related to wound care are being reviewed and re-written.

With regard to the data system, we anticipate that the new EHR will help significantly. The quality team has begun to evaluate the new inpatient EHR, Soarian, to see how it can be used to improve HAPU documentation and tracking and communication. Currently, transmission of information about pressure ulcers is dependent on communication during each shift or care team hand-off. The only electronic tracking system is the occurrence reporting system, which has inherent limitations as it is dependent on the accuracy and timeliness of individual staff members' documentation in the system.

Other activities that we engaged in during this period included a back to the basics training for Highland bedside nurses, which included reinforcement of the turning schedule and adding a posted visual aid for turning in every room. In addition, ACMC has joined the NAPH safety network for HAPU & SSI regional learning collaborative and a team went to the Safety Network regional collaborative meeting in Houston.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	yes
Achievement Value	1.00