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

Dates Reports are Due	

DPH systems submit this report to the State three times a year:

DY 6 (6-month)	March 2, 2011
DY 6 (year-end)	May 15, 2011
DY 7 (6-month)	March 31, 2012
DY 7 (12-month)	September 30, 2012
DY 7 (year-end)	October 31, 2012
DY 8 (6-month)	March 31, 2013
DY 8 (12-month)	September 30, 2013
DY 8 (year-end)	October 31, 2013
DY 9 (6-month)	March 31, 2014
DY 9 (12-month)	September 30, 2014
DY 9 (year-end)	October 31, 2014
DY 10 (6-month)	March 31, 2015
DY 10 (12-month)	September 30, 2015
DY 10 (year-end)	October 31, 2015

Use of This Reporting Form

All DPH systems must use this Reporting Form template for reports starting May 15, 2011. For the annual report, DPH systems will include the annual report narrative, the annual report, and reattach the previously submitted 6-month report. The State reserves its right to modify the Reporting Form as experience is gained with its use. The State is looking for DPHs to include as much detail as possible in their narrative responses throughout the Reporting Form. Given the timeframe the State has to review and make payment, the State will exercise its right to further review the submitted Reporting Forms even after payment is made and, if necessary, recoup payment if it is determined on further review that a milestone was not met.

DPH systems should follow the instructions at the top of each tab for completing the form. DPH systems must complete information for items marked "*" for every project and every milestone included in the DPH's plan for that DY. Regardless of whether there is any progress made on a particular milestone, DPH systems must include ALL of the milestones included in their plans for that DY in the Reporting Form and report progress or no progress so that the form appropriately calculates the total denominator of the achievement values for purposes of accurate payment. DPH systems should not include any milestones from any other DYs other than the DY for which the report is due.

For milestones that can receive partial payment (e.g, the milestone is "achieve 90% compliance with the bundle"), please complete the numerator and denominator information for that milestone, and include the targeted achievement under "DY Target" for calculation of a 0, 0.25, 0.5, 0.75, or 1 achievement value. For an "all-or-nothing" milestones (e.g., the milestone is "join a sepsis collaborative"), please use the "yes/no" drop-down menu and under "DY Target" enter "yes". For some milestones that are "yes/no," but are also the reporting of data (e.g., the milestone is "report baseline data"), it may make sense to use the "yes/no" drop-down menu, under "DY Target" enter "yes", and include the actual data in the numerator and denominator for reporting purposes only (the payment will be based on selecting "yes" or "no").

In the narrative summary box for each milestone, DPHs must include an assessment of overall project implementation, including brief but detailed narrative descriptions of:
- a. the results of any milestones achieved or milestone progress, as applicable
- b. barriers to meeting any milestones and how those barriers have been addressed
- c. the approaches taken to test, refine and improve upon specific interventions, including examples of "Plan Do Study Act" learning cycles
- d. how staff have used data to test implementation methods
- e. lessons learned and key changes implemented, as applicable
- f. how projects have informed the modification and scaling up of other projects, as applicable
- g. training programs, including outlines of curricula, the frequency of trainings, and a summary of the results of training evaluations as applicable
- h. the process to involve stakeholders in the project, as applicable
- i. system-level changes that have been made, if any, as a result of the project
- j. engagement by physicians, front line clinicians and patients in the projects and the degree to which this engagement is contributing to the success of the project
- k. plans for sustainability of the project, given staff turnover, and plans for ongoing staff training

 In addition to providing an in-depth description of how the milestone was achieved, please also provide an in-depth description of why a milestone was not achieved or only partially achieved, for the purposes of understanding systemic issues/patterns. If DPH systems are reporting at the 6-month mark and a milestone is partially met or not achieved because it will be more fully achieved by the year-end of the DY, the DPH system may note that it is on track to meet the milestone within the DY. As stated above, the State is looking for DPHs to provide detailed descriptions of milestone progress in their narrative responses throughout the Reporting Form.

Payment amounts are in Total Computable (i.e., federal incentive and non-federal share provided by DPHs). Indicate all payment amounts as a whole number (i.e., do not round, do not show in millions with decimals). For the 6-month report (first semi-annual report of the DY), DPHs would not have received any prior funding for the DY and therefore should enter "0" for all of the DPH's projects under: "Incentive Funding Already Received in DY."

For the **Annual Report**, DPHs must report any updates, corrections or changes to the data for a given milestone, and must highlight the change in yellow. Additionally, DPHs must provide an explanation for the correction or change in the narrative summary box for that milestone. The narrative explanation should be additive, meaning that it should be added to the original narrative provided for that milestone.

This reporting form is counting all of those milestones that are ___required___ for all DPHs in Categories 3-4 in DY7 currently. The reporting form will need to be revised accordingly for future DYs to also automatically count required milestones for those DYs.

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP

* **DPH SYSTEM:**	Santa Clara Valley Medical Center
* **REPORTING YEAR:**	DY 7
* **DATE OF SUBMISSION:**	9/28/2012

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	$
Increase Training of Primary Care Workforce	
Implement and Utilize Disease Management Registry Functionality	$ 7,708,333.33
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	
Enhance Performance Improvement and Reporting Capacity	
TOTAL CATEGORY 1 INCENTIVE PAYMENT:	$ 7,708,333.33
Category 2 Projects	
Expand Medical Homes	
Expand Chronic Care Management Models	$ 1,812,500.00
Redesign Primary Care	
Redesign to Improve Patient Experience	$ 1,562,500.00
Redesign for Cost Containment	$ 1,170,333.33
Integrate Physical and Behavioral Health Care	$ 9,666,666.67
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	
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:	$ 14,212,000.00
Category 3 Domains	
Patient/Care Giver Experience *(required)*	$ 3,163,875.00
Care Coordination *(required)*	$ 3,163,875.00
Preventive Health *(required)*	$ 3,163,875.00
At-Risk Populations *(required)*	$ 3,163,875.00
TOTAL CATEGORY 3 INCENTIVE PAYMENT:	$ 12,655,500.00
Category 4 Interventions	
Severe Sepsis Detection and Management *(required)*	$ 198,305.56
Central Line Associated Blood Stream Infection Prevention *(required)*	$ 1,561,656.25
Surgical Site Infection Prevention	$ 1,070,850.00
Hospital-Acquired Pressure Ulcer Prevention	$ 520,254.62
Stroke Management	
Venous Thromboembolism (VTE) Prevention and Treatment	
Falls with Injury Prevention	
TOTAL CATEGORY 4 INCENTIVE PAYMENT:	$ 3,351,066.43
TOTAL INCENTIVE PAYMENT	$ 37,926,899.76

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012
Annual Report Narrative

This narrative summarizes the DSRIP activities performed in the reporting demonstration year.
 * Instructions for DPH systems: Please complete the narrative for annual reports. The narrative must include
a description of the degree to which each project contributed to the advancement of the broad delivery system reform relevant
to the patient population that was included in the DPHs DSRIP Plan. The narrative must also include a detailed description of
participation in shared learning.

Summary of Demonstration Year Activities

Summary of DPH System's Participation in Shared Learning

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

Category 1 Summary Page

This table is the summary of data reported for the DPH system. Please see the following pages for the specifics.
* Instructions for DPH systems: Do not complete, this tab will automatically populate.

☐ The black boxes indicate Milestone achievements, either "yes/no", or the actual achievement # or %.
☐ The blue boxes show progress made toward the Milestone ("Achievement Value") of 1.0, 0.75. 0.5, 0.25 or 0.
☐ The red boxes indicate Total Sums.

Category 1 Projects

Expand Primary Care Capacity

Process Milestone:	1. Maintain the Office of Panel Management, such that panel capacity is continuously optimized. Develop a plan for scoring paneled patients for complexity	Yes
Achievement Value		1.00
Process Milestone:	2. Increase primary care clinic volume. Hire additional primary care providers and support staff to increase primary care adult medicine panel capacity to 46,000 patients.	Yes
Achievement Value		1.00
Process Milestone:	3. Develop a plan and gain approval to design and construct an additional 60,000 sq. foot primary care clinic in the underserved downtown San Jose urban core.	Yes
Achievement Value		1.00
Process Milestone:	4. Implement a system to accommodate urgent care needs in at least two primary care clinics, as measured by achieving at least 20% of paneled patients scheduled within 7 calendar days.	Yes
Achievement Value		1.00
Process Milestone:	5. Expand the hours of at least two primary care clinics by at least 16 hours per week.	Yes
Achievement Value		1.00
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ 18,500,000.00
Total Sum of Achievement Values:	5.00
Total Number of Milestones:	5.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 18,500,000.00
Incentive Funding Already Received in DY:	$ 18,500,000.00
Incentive Payment Amount:	$

DSRIP Semi-Annual Reporting Form

Category 1 Summary Page

Increase Training of Primary Care Workforce		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
DY Total Computable Incentive Amount:		$ -
Total Sum of Achievement Values:		-
Total Number of Milestones:		-
Achievement Value Percentage:		
Eligible Incentive Funding Amount:		
Incentive Funding Already Received in DY:		$ -
Incentive Payment Amount:		

DSRIP Semi-Annual Reporting Form

Category 1 Summary Page

Implement and Utilize Disease Management Registry Functionality

Process Milestone:	1. Review future potential registry platforms and select registry platform.	Yes
Achievement Value		1.00
Process Milestone:	2. Implement/expand a functional disease registry in at least 25% (2 out of 7) of medical home teams.	Yes
Achievement Value		1.00
Process Milestone:	3. Conduct training on registry platform for relevant staff members in at least 25% (2 out of 7) of medical home teams.	Yes
Achievement Value		1.00
Process Milestone:	4. Demonstrate registry reporting ability to track and report on at least 2 selected metrics.	Yes
Achievement Value		1.00
Process Milestone:	5. Enter patient data into the registry - interface at least 2 data categories or sources to registry for adult primary care clinic patients.	Yes
Achievement Value		1.00
Improvement Milestone:	6. Implement and staff cross-functional team to develop and operate registry program.	Yes
Achievement Value		1.00
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ 18,500,000.00
Total Sum of Achievement Values:	6.00
Total Number of Milestones:	6.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 18,500,000.00
Incentive Funding Already Received in DY:	$ 10,791,666.67
Incentive Payment Amount:	$ 7,708,333.33

Category 1 Summary Page

Enhance Interpretation Services and Culturally Competent Care		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
DY Total Computable Incentive Amount:		$ -
Total Sum of Achievement Values:		-
Total Number of Milestones:		-
Achievement Value Percentage:		
Eligible Incentive Funding Amount:		
Incentive Funding Already Received in DY:		$ -
Incentive Payment Amount:		

DSRIP Semi-Annual Reporting Form

Category 1 Summary Page
Collect Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities

Process Milestone: _____ - | N/A |
  Achievement Value | |

Process Milestone: _____ - | N/A |
  Achievement Value | |

Process Milestone: _____ - | N/A |
  Achievement Value | |

Process Milestone: _____ - | N/A |
  Achievement Value | |

Process Milestone: _____ - | N/A |
  Achievement Value | |

Improvement Milestone: _____ - | N/A |
  Achievement Value | |

Improvement Milestone: _____ - | N/A |
  Achievement Value | |

Improvement Milestone: _____ - | N/A |
  Achievement Value | |

Improvement Milestone: _____ - | N/A |
  Achievement Value | |

Improvement Milestone: _____ - | N/A |
  Achievement Value | |

DY Total Computable Incentive Amount: | $ - |

Total Sum of Achievement Values: | - |

Total Number of Milestones: | - |

Achievement Value Percentage: | |

Eligible Incentive Funding Amount: | |

Incentive Funding Already Received in DY: | $ - |

Incentive Payment Amount: | |

DSRIP Semi-Annual Reporting Form

Category 1 Summary Page

Enhance Urgent Medical Advice

Process Milestone: _____ - | N/A |

Achievement Value

Process Milestone: _____ - | N/A |

Achievement Value

Process Milestone: _____ - | N/A |

Achievement Value

Process Milestone: _____ - | N/A |

Achievement Value

Process Milestone: _____ - | N/A |

Achievement Value

Improvement Milestone: _____ - | N/A |

Achievement Value

Improvement Milestone: _____ - | N/A |

Achievement Value

Improvement Milestone: _____ - | N/A |

Achievement Value

Improvement Milestone: _____ - | N/A |

Achievement Value

Improvement Milestone: _____ - | N/A |

Achievement Value

DY Total Computable Incentive Amount: | $ - |

Total Sum of Achievement Values: | - |

Total Number of Milestones: | - |

Achievement Value Percentage: | |

Eligible Incentive Funding Amount: | |

Incentive Funding Already Received in DY: | $ - |

Incentive Payment Amount: | |

Category 1 Summary Page

Introduce Telemedicine

Process Milestone: _____ - | N/A |

Achievement Value

Process Milestone: _____ - | N/A |

Achievement Value

Process Milestone: _____ - | N/A |

Achievement Value

Process Milestone: _____ - | N/A |

Achievement Value

Process Milestone: _____ - | N/A |

Achievement Value

Improvement Milestone: _____ - | N/A |

Achievement Value

Improvement Milestone: _____ - | N/A |

Achievement Value

Improvement Milestone: _____ - | N/A |

Achievement Value

Improvement Milestone: _____ - | N/A |

Achievement Value

Improvement Milestone: _____ - | N/A |

Achievement Value

DY Total Computable Incentive Amount: | $ - |

Total Sum of Achievement Values: | - |

Total Number of Milestones: | - |

Achievement Value Percentage: | |

Eligible Incentive Funding Amount: | |

Incentive Funding Already Received in DY: | $ - |

Incentive Payment Amount:

DSRIP Semi-Annual Reporting Form

Category 1 Summary Page

Enhance Coding and Documentation for Quality Data

Process Milestone:	- N/A
Achievement Value	
Process Milestone:	- N/A
Achievement Value	
Process Milestone:	- N/A
Achievement Value	
Process Milestone:	- N/A
Achievement Value	
Process Milestone:	- N/A
Achievement Value	
Improvement Milestone:	- N/A
Achievement Value	
Improvement Milestone:	- N/A
Achievement Value	
Improvement Milestone:	- N/A
Achievement Value	
Improvement Milestone:	- N/A
Achievement Value	
Improvement Milestone:	- N/A
Achievement Value	

DY Total Computable Incentive Amount:	$ -
Total Sum of Achievement Values:	-
Total Number of Milestones:	-
Achievement Value Percentage:	
Eligible Incentive Funding Amount:	
Incentive Funding Already Received in DY:	$ -
Incentive Payment Amount:	

DSRIP Semi-Annual Reporting Form

Category 1 Summary Page
Develop Risk Stratification Capabilities/Functionalities

Process Milestone: _____ - | N/A |
    Achievement Value | |

Process Milestone: _____ - | N/A |
    Achievement Value | |

Process Milestone: _____ - | N/A |
    Achievement Value | |

Process Milestone: _____ - | N/A |
    Achievement Value | |

Process Milestone: _____ - | N/A |
    Achievement Value | |

Improvement Milestone: _____ - | N/A |
    Achievement Value | |

Improvement Milestone: _____ - | N/A |
    Achievement Value | |

Improvement Milestone: _____ - | N/A |
    Achievement Value | |

Improvement Milestone: _____ - | N/A |
    Achievement Value | |

Improvement Milestone: _____ - | N/A |
    Achievement Value | |

DY Total Computable Incentive Amount: | $ - |

Total Sum of Achievement Values: | - |

Total Number of Milestones: | - |

Achievement Value Percentage: | |

Eligible Incentive Funding Amount: | |

Incentive Funding Already Received in DY: | $ - |

<u>Incentive Payment Amount:</u> | |

DSRIP Semi-Annual Reporting Form

Expand Specialty Care Capacity

Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ -
Total Sum of Achievement Values:	-
Total Number of Milestones:	-
Achievement Value Percentage:	
Eligible Incentive Funding Amount:	
Incentive Funding Already Received in DY:	$ -
Incentive Payment Amount:	

DSRIP Semi-Annual Reporting Form

Category 1 Summary Page
Enhance Performance Improvement and Reporting Capacity

Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ -
Total Sum of Achievement Values:	-
Total Number of Milestones:	-
Achievement Value Percentage:	
Eligible Incentive Funding Amount:	
Incentive Funding Already Received in DY:	$ -
Incentive Payment Amount:	

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

Category 2 Summary Page

This table is the summary of data reported for the DPH system. Please see the following pages for the specifics.
* *Instructions for DPH systems: Do not complete, this tab will automatically populate.*

☐ The black boxes indicate Milestone achievements, either "yes/no", or the actual achievement # or %.

☐ The blue boxes show progress made toward the Milestone ("Achievement Value") of 1.0, 0.75. 0.5, 0.25 or 0.

☐ The red boxes indicate Total Sums.

Category 2 Projects	
Expand Medical Homes	
Process Milestone: _____ -	N/A
Achievement Value	
Process Milestone: _____ -	N/A
Achievement Value	
Process Milestone: _____ -	N/A
Achievement Value	
Process Milestone: _____ -	N/A
Achievement Value	
Process Milestone: _____ -	N/A
Achievement Value	
Improvement Milestone: _____ -	N/A
Achievement Value	
Improvement Milestone: _____ -	N/A
Achievement Value	
Improvement Milestone: _____ -	N/A
Achievement Value	
Improvement Milestone: _____ -	N/A
Achievement Value	
Improvement Milestone: _____ -	N/A
Achievement Value	
DY Total Computable Incentive Amount:	$ -
Total Sum of Achievement Values:	-
Total Number of Milestones:	-
Achievement Value Percentage:	
Eligible Incentive Funding Amount:	
Incentive Funding Already Received in DY:	$ -
Incentive Payment Amount:	

DSRIP Semi-Annual Reporting Form

Category 2 Summary Page

Expand Chronic Care Management Models		
Process Milestone:	1. Formalize multi-disciplinary teams.	Yes
Achievement Value		1.00
Process Milestone:	2. Train staff in components of the care model including quality measurement, primary care redesign, and financing chronic care model.	Yes
Achievement Value		1.00
Process Milestone:	3. Train relevant staff in the chronic care model in at least 25% (2 out of 7) of medical home teams.	Yes
Achievement Value		1.00
Process Milestone:	4. Utilize elements of chronic care model in at least 25% (2 out of 7) of medical home teams.	Yes
Achievement Value		1.00
Process Milestone:	5. Implement program to identify and manage targeted patients needing further clinical intervention for at least 1 outcome.	N/A
Achievement Value		1.00
Improvement Milestone:	6. Apply the chronic care model to the management of glycemic control and dyslipidemia in diabetes.	Yes
Achievement Value		1.00
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ 14,500,000.00
Total Sum of Achievement Values:	6.00
Total Number of Milestones:	6.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 14,500,000.00
Incentive Funding Already Received in DY:	$ 12,687,500.00
Incentive Payment Amount:	$ 1,812,500.00

DSRIP Semi-Annual Reporting Form

Category 2 Summary Page
Redesign Primary Care

Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ -
Total Sum of Achievement Values:	-
Total Number of Milestones:	-
Achievement Value Percentage:	
Eligible Incentive Funding Amount:	
Incentive Funding Already Received in DY:	$ -
Incentive Payment Amount:	

DSRIP Semi-Annual Reporting Form

Category 2 Summary Page

Redesign to Improve Patient Experience

Process Milestone:	1. Include key stake holders in assessment of patient experience tool.	Yes
Achievement Value		1.00
Process Milestone:	2. Write and obtain approval for SCVMC patient/family experience strategic plan.	Yes
Achievement Value		1.00
Process Milestone:	3. Sub-committees implement plans to improve: First contact and inpatient noise.	Yes
Achievement Value		1.00
Process Milestone:	4. Implement plans for regular organization-wide communication of patient experience data and efforts to improve patient/family experience.	Yes
Achievement Value		1.00
Process Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ 5,000,000.00
Total Sum of Achievement Values:	4.00
Total Number of Milestones:	4.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 5,000,000.00
Incentive Funding Already Received in DY:	$ 3,437,500.00
Incentive Payment Amount:	$ 1,562,500.00

DSRIP Semi-Annual Reporting Form

Category 2 Summary Page

<div style="border:1px solid black">

Redesign for Cost Containment

Process Milestone:	1. Continued implementation of a cost accounting system to measure intervention	Yes
Achievement Value		0.75
Process Milestone:	2. Develop/identify a cost accounting methodology to quantify the financial impact of quality and efficiency improvement interventions.	Yes
Achievement Value		1.00
Process Milestone:	3. Establish a baseline for cost	Yes
Achievement Value		0.50
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ 3,511,000.00
Total Sum of Achievement Values:	2.25
Total Number of Milestones:	3.00
Achievement Value Percentage:	75%
Eligible Incentive Funding Amount:	$ 2,633,250.00
Incentive Funding Already Received in DY:	$ 1,462,916.67
Incentive Payment Amount:	$ 1,170,333.33

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DSRIP Semi-Annual Reporting Form

Category 2 Summary Page

Integrate Physical and Behavioral Health Care

Process Milestone:	1. Implement IMPACT training of behavioral health and primary care staff within four primary care settings.	Yes
Achievement Value		1.00
Process Milestone:	2. 500 primary care patients will be provided behavioral health services by end of Year Two.	N/A
Achievement Value		1.00
Process Milestone:	3. Design, test, and finalize protocol for patient referral process into Federally Qualified Health Centers (FQHC)-BH services.	Yes
Achievement Value		1.00
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ 14,500,000.00
Total Sum of Achievement Values:	3.00
Total Number of Milestones:	3.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 14,500,000.00
Incentive Funding Already Received in DY:	$ 4,833,333.33
Incentive Payment Amount:	$ 9,666,666.67

Category 2 Summary Page

Increase Specialty Care Access/Redesign Referral Process

Process Milestone: _____ - | N/A |
   Achievement Value

Process Milestone: _____ - | N/A |
   Achievement Value

Process Milestone: _____ - | N/A |
   Achievement Value

Process Milestone: _____ - | N/A |
   Achievement Value

Process Milestone: _____ - | N/A |
   Achievement Value

Improvement Milestone: _____ - | N/A |
   Achievement Value

Improvement Milestone: _____ - | N/A |
   Achievement Value

Improvement Milestone: _____ - | N/A |
   Achievement Value

Improvement Milestone: _____ - | N/A |
   Achievement Value

Improvement Milestone: _____ - | N/A |
   Achievement Value

DY Total Computable Incentive Amount: | $ - |

Total Sum of Achievement Values: | - |

Total Number of Milestones: | - |

Achievement Value Percentage: | |

Eligible Incentive Funding Amount: | |

Incentive Funding Already Received in DY: | $ - |

Incentive Payment Amount: | |

DSRIP Semi-Annual Reporting Form

Category 2 Summary Page

Establish/Expand a Patient Care Navigation Program

Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ -
Total Sum of Achievement Values:	-
Total Number of Milestones:	-
Achievement Value Percentage:	
Eligible Incentive Funding Amount:	
Incentive Funding Already Received in DY:	$ -
Incentive Payment Amount:	

Category 2 Summary Page

Apply Process Improvement Methodology to Improve Quality/Efficiency

Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ -
Total Sum of Achievement Values:	-
Total Number of Milestones:	-
Achievement Value Percentage:	
Eligible Incentive Funding Amount:	
Incentive Funding Already Received in DY:	$ -
Incentive Payment Amount:	

DSRIP Semi-Annual Reporting Form

Category 2 Summary Page

Improve Patient Flow in the Emergency Department/Rapid Medical Evaluation

Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ -
Total Sum of Achievement Values:	-
Total Number of Milestones:	-
Achievement Value Percentage:	
Eligible Incentive Funding Amount:	
Incentive Funding Already Received in DY:	$ -
Incentive Payment Amount:	

Category 2 Summary Page

Use Palliative Care Programs

Process Milestone:		-	N/A
Achievement Value			
Process Milestone:		-	N/A
Achievement Value			
Process Milestone:		-	N/A
Achievement Value			
Process Milestone:		-	N/A
Achievement Value			
Process Milestone:		-	N/A
Achievement Value			
Improvement Milestone:		-	N/A
Achievement Value			
Improvement Milestone:		-	N/A
Achievement Value			
Improvement Milestone:		-	N/A
Achievement Value			
Improvement Milestone:		-	N/A
Achievement Value			
Improvement Milestone:		-	N/A
Achievement Value			

DY Total Computable Incentive Amount: $ -

Total Sum of Achievement Values: -

Total Number of Milestones: -

Achievement Value Percentage:

Eligible Incentive Funding Amount:

Incentive Funding Already Received in DY: $ -

Incentive Payment Amount:

Category 2 Summary Page
Conduct Medication Management

Process Milestone: - N/A
Achievement Value

Process Milestone: - N/A
Achievement Value

Process Milestone: - N/A
Achievement Value

Process Milestone: - N/A
Achievement Value

Process Milestone: - N/A
Achievement Value

Improvement Milestone: - N/A
Achievement Value

Improvement Milestone: - N/A
Achievement Value

Improvement Milestone: - N/A
Achievement Value

Improvement Milestone: - N/A
Achievement Value

Improvement Milestone: - N/A
Achievement Value

DY Total Computable Incentive Amount: $ -

Total Sum of Achievement Values: -

Total Number of Milestones: -

Achievement Value Percentage:

Eligible Incentive Funding Amount:

Incentive Funding Already Received in DY: $ -

Incentive Payment Amount:

DSRIP Semi-Annual Reporting Form

Category 2 Summary Page
Implement/Expand Care Transitions Programs

Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ -
Total Sum of Achievement Values:	-
Total Number of Milestones:	-
Achievement Value Percentage:	
Eligible Incentive Funding Amount:	
Incentive Funding Already Received in DY:	$ -
Incentive Payment Amount:	

DSRIP Semi-Annual Reporting Form

Category 2 Summary Page

Implement Real-Time Hospital-Acquired Infections (HAIs) System

Process Milestone: _____ - | N/A |
  Achievement Value

Process Milestone: _____ - | N/A |
  Achievement Value

Process Milestone: _____ - | N/A |
  Achievement Value

Process Milestone: _____ - | N/A |
  Achievement Value

Process Milestone: _____ - | N/A |
  Achievement Value

Improvement Milestone: _____ - | N/A |
  Achievement Value

Improvement Milestone: _____ - | N/A |
  Achievement Value

Improvement Milestone: _____ - | N/A |
  Achievement Value

Improvement Milestone: _____ - | N/A |
  Achievement Value

Improvement Milestone: _____ - | N/A |
  Achievement Value

DY Total Computable Incentive Amount: | $ - |

Total Sum of Achievement Values: | - |

Total Number of Milestones: | - |

Achievement Value Percentage: | |

Eligible Incentive Funding Amount: | |

Incentive Funding Already Received in DY: | $ - |

Incentive Payment Amount:

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

Category 3 Summary Page

This table is the summary of data reported for the DPH system. Please see the following pages for the specifics.
* Instructions for DPH systems: Do not complete, this tab will automatically populate.

☐ The black boxes indicate Milestone achievements, either "yes/no", or the actual achievement # or %.
☐ The blue boxes show progress made toward the Milestone ("Achievement Value") of 1.0, 0.75. 0.5, 0.25 or 0.
☐ The red boxes indicate Total Sums.

Category 3 Domains	
Patient/Care Giver Experience (required)	
Undertake the necessary planning, redesign, translation, training and contrac negotiations in order to implement CG-CAHPS in DY8 (DY7 only)	Yes
Achievement Value	1.00
Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme to the State (DY8-10)	N/A
Achievement Value	
Report results of CG CAHPS questions for "How Well Doctors Communicate With Patients" theme to the State (DY8-10)	N/A
Achievement Value	
Report results of CG CAHPS questions for "Helpful, Courteous, and Respectful Office Staff" theme to the State (DY8-10)	N/A
Achievement Value	
Report results of CG CAHPS questions for "Patients' Rating of the Doctor" theme to the State (DY8-10)	N/A
Achievement Value	
Report results of CG CAHPS questions for "Shared Decisionmaking" theme to the State (DY8-10)	N/A
Achievement Value	
DY Total Computable Incentive Amount:	$ 6,327,750.00
Total Sum of Achievement Values:	1.00
Total Number of Milestones:	1.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 6,327,750.00
Incentive Funding Already Received in DY:	$ 3,163,875.00
Incentive Payment Amount:	$ 3,163,875.00

DSRIP Semi-Annual Reporting Form

Category 3 Summary Page

Care Coordination (required)

Report results of the Diabetes, short-term complications measure to the State (DY7-10)	Yes
Achievement Value	1.00
Report results of the Uncontrolled Diabetes measure to the State (DY7-10)	Yes
Achievement Value	1.00
Report results of the Congestive Heart Failure measure to the State (DY8-10)	N/A
Achievement Value	
Report results of the Chronic Obstructive Pulmonary Disease measure to the State (DY8-10)	N/A
Achievement Value	
DY Total Computable Incentive Amount:	$ 6,327,750.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	2.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 6,327,750.00
Incentive Funding Already Received in DY:	$ 3,163,875.00
Incentive Payment Amount:	$ 3,163,875.00

Preventive Health (required)

Report results of the Mammography Screening for Breast Cancer measure to the State (DY7-10)	Yes
Achievement Value	1.00
Reports results of the Influenza Immunization measure to the State (DY7-10)	Yes
Achievement Value	*1.00*
Report results of the Child Weight Screening measure to the State (DY8-10)	N/A
Achievement Value	
Report results of the Pediatrics Body Mass Index (BMI) measure to the State (DY8-10)	N/A
Achievement Value	
Report results of the Tobacco Cessation measure to the State (DY8-10)	N/A
Achievement Value	
DY Total Computable Incentive Amount:	$ 6,327,750.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	2.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 6,327,750.00
Incentive Funding Already Received in DY:	$ 3,163,875.00
Incentive Payment Amount:	$ 3,163,875.00

Category 3 Summary Page

At-Risk Populations (required)	
Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State (DY7-10)	Yes
Achievement Value	1.00
Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<8%) measure to the State (DY7-10)	Yes
Achievement Value	*1.00*
Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State (DY8-10)	N/A
Achievement Value	
Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State (DY8-10)	N/A
Achievement Value	
Report results of the Pediatrics Asthma Care measure to the State (DY8-10)	N/A
Achievement Value	
Report results of the Optimal Diabetes Care Composite to the State (DY8-10)	N/A
Achievement Value	
Report results of the Diabetes Composite to the State (DY8-10)	N/A
Achievement Value	
DY Total Computable Incentive Amount:	$ 6,327,750.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	2.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 6,327,750.00
Incentive Funding Already Received in DY:	$ 3,163,875.00
Incentive Payment Amount:	$ 3,163,875.00

DSRIP Semi-Annual Reporting Form

Category 4 Summary Page

This table is the summary of data reported for the DPH system. Please see the following pages for the specifics.

* Instructions for DPH systems: Do not complete, this tab will automatically populate.

☐ The black boxes indicate Milestone achievements, either "yes/no", or the actual achievement # or %.

☐ The blue boxes show progress made toward the Milestone ("Achievement Value") of 1.0, 0.75. 0.5, 0.25 or 0.

☐ The red boxes indicate Total Sums.

Category 4 Interventions	
Severe Sepsis Detection and Management *(required)*	

Compliance with Sepsis Resuscitation bundle (%)	0.40
Achievement Value	*1.00*
Optional Milestone: 1. Establish which parameters for data monitoring for Severe Sepsis will be utilized.	-
Achievement Value	*1.00*
Optional Milestone: 2. Arrange dedicated Sepsis RN for retrospective and concurrent chart reviews of all Sepsis/Severe Sepsis/Septic Shock patients.	Yes
Achievement Value	*1.00*
Optional Milestone: 3. Assign data analyst to help with data management/establishment of a database, and reporting of data to Safety Net Institute SNI/State.	Yes
Achievement Value	*1.00*
Optional Milestone: 4. Retrospectively review all Sepsis patient charts from a 6 month period in 2011 to establish baseline.	Yes
Achievement Value	*1.00*
Optional Milestone: 5. Participate in the BEACON collaborative to learn and share best practices related to improving Severe Sepsis and Septic Shock detection and management.	Yes
Achievement Value	*1.00*
Optional Milestone: 6. Develop plans for a hospital-wide Sepsis Screening Program.	Yes
Achievement Value	*1.00*
Optional Milestone: 7. Implement the four strongest elements of the Sepsis Resuscitation Bundle for which there is the most evidence of reliability and efficacy (based on the recommendations of the Gordon and Betty Moore Foundation's Integrated Nurse Leadership Program and other sepsis prevention collaborative): as evidenced by the completion within 6 hours for patients with Severe Sepsis, Septic Shock, and/or lactate > 4 mmol/L (36 mg/dl) of the following: Serum lactate measured, blood cultures obtained prior to antibiotic administration, improve time to broad-spectrum antibiotics: within 3 hours for ED admissions and 1 hour for non-ED ICU admissions, in the event of hypotension and/or lactate > 4 mmol/L (36 mg/dl): deliver an initial minimum of 20 mL/kg of crystalloid (or colloid equivalent), apply vasopressors for hypotension not responding to initial fluid resuscitation to maintain mean arterial pressure (MAP) > 65 mm Hg. As evidenced by either a report from chart review or database	Yes
Achievement Value	*1.00*
Optional Milestone: 8. Report at least 6 months of data collection on Sepsis Resuscitation Bundle to SNI for purpose of establishing the baseline and setting benchmarks.	Yes
Achievement Value	*1.00*

DSRIP Semi-Annual Reporting Form

Category 4 Summary Page

Optional Milestone:		-	-
Achievement Value			N/A
Optional Milestone:		-	N/A
Achievement Value			

DY Total Computable Incentive Amount:	$ 3,569,500.00
Total Sum of Achievement Values:	9.00
Total Number of Milestones:	9.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 3,569,500.00
Incentive Funding Already Received in DY:	$ 3,371,194.44
Incentive Payment Amount:	$ 198,305.56

DSRIP Semi-Annual Reporting Form

Category 4 Summary Page
Central Line Associated Blood Stream Infection Prevention *(required)*

Compliance with Central Line Insertion Practices (CLIP) (%)	96.00
Achievement Value	1.00
Optional Milestone: 1. Implement the Central Line Insertion Practices (CLIP), as evidenced by data reported to the NHSN via the CLIP adherence monitoring form and daily documentation of line necessity.	Yes
Achievement Value	*1.00*
Optional Milestone: 2. Report at least 6 months of data collection on CLIP to SNI for purposes of establishing the baseline and setting benchmarks.	Yes
Achievement Value	*1.00*
Optional Milestone: 3. Report at least 6 months of data collection on CLABSI to SNI for purposes of establishing the baseline and setting benchmarks.	Yes
Achievement Value	*1.00*
Optional Milestone: -	-
Achievement Value	*N/A*
Optional Milestone: -	N/A
Achievement Value	
Optional Milestone: -	N/A
Achievement Value	
Optional Milestone: -	N/A
Achievement Value	
Optional Milestone: -	N/A
Achievement Value	
Optional Milestone: -	N/A
Achievement Value	

DY Total Computable Incentive Amount:	$ 3,569,500.00
Total Sum of Achievement Values:	4.00
Total Number of Milestones:	4.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 3,569,500.00
Incentive Funding Already Received in DY:	$ 2,007,843.75
Incentive Payment Amount:	$ 1,561,656.25

DSRIP Semi-Annual Reporting Form

Category 4 Summary Page

Surgical Site Infection Prevention

Rate of surgical site infection for Class 1 and 2 wounds (%)		N/A
Achievement Value		N/A
Optional Milestone:	1. Develop SCIP based preprinted order sets and update all existing preprinted surgical core sets to reflect current SCIP guidelines.	Yes
Achievement Value		1.00
Optional Milestone:	2. Develop a process where the proper preprinted order set is included in the preoperative packet to improve compliance.	Yes
Achievement Value		1.00
Optional Milestone:	3. Continue with educational models for attending staff, house staff, perioperative staff and medical/surgical unit nursing on current evidence based SCIP guidelines	Yes
Achievement Value		1.00
Optional Milestone:	4. Implement quality checklists on the formatted inpatient notes	Yes
Achievement Value		1.00
Optional Milestone:	5. Continue to measure and report compliance with SCIP process measures	N/A
Achievement Value		1.00
Optional Milestone:	-	N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ 3,569,500.00
Total Sum of Achievement Values:	5.00
Total Number of Milestones:	5.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 3,569,500.00
Incentive Funding Already Received in DY:	$ 2,498,650.00
Incentive Payment Amount:	$ 1,070,850.00

DSRIP Semi-Annual Reporting Form

Category 4 Summary Page

Hospital-Acquired Pressure Ulcer Prevention

Prevalence of Stage II, III, IV or unstageable pressure ulcers (%)		0.01
Achievement Value		1.00
Optional Milestone:	1. Collect data: Process measures	Yes
Achievement Value		*1.00*
Optional Milestone:	2. Collect data: Patient outcomes	Yes
Achievement Value		*1.00*
Optional Milestone:	3. Examine HAPU versus ulcers occurring prior to admission and wound healing or progression	Yes
Achievement Value		*1.00*
Optional Milestone:	4. Implement best practice via evidence-based practice.	Yes
Achievement Value		*1.00*
Optional Milestone:	5. Physician education on elements, wound staging, specialty bed selection, care management and best practices.	Yes
Achievement Value		*1.00*
Optional Milestone:	6. Reinforce use of "Turn Log".	Yes
Achievement Value		*1.00*
Optional Milestone:	Optional Milestone: 7. Add management oversight to the Skin Care Team. Ensure every adult unit has a "Champion",	Yes
Achievement Value		*1.00*
Optional Milestone:	8. Institute education rounds by Skin Care Team Champions	Yes
Achievement Value		*1.00*
Optional Milestone:	9. Share results of data baseline with staff	Yes
Achievement Value		*1.00*
Optional Milestone:	Optional Milestone: 10. Share data, promising practices, and findings with SNI to foster shared learning and benchmarking across the California public hospitals.	Yes
Achievement Value		*1.00*
Optional Milestone:	11. Report HAPU stage III or greater to California Dept. of Public Health (CDPH)	Yes
Achievement Value		*1.00*
Optional Milestone:	12. Report HAPU Prevalence to CDPH	N/A
Achievement Value		*N/A*
Optional Milestone:	13. Begin PDSA rapid change cycles	N/A
Achievement Value		*100.00%*
DY Total Computable Incentive Amount:		$ 3,569,500.00
Total Sum of Achievement Values:		13.00
Total Number of Milestones:		13.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 3,569,500.00
Incentive Funding Already Received in DY:		$ 3,049,245.38
Incentive Payment Amount:		$ 520,254.62

Category 4 Summary Page

Stroke Management			
Optional Milestone:		-	N/A
Achievement Value			
Optional Milestone:		-	N/A
Achievement Value			
Optional Milestone:		-	N/A
Achievement Value			
Optional Milestone:		-	N/A
Achievement Value			
Optional Milestone:		-	N/A
Achievement Value			
Optional Milestone:		-	N/A
Achievement Value			
DY Total Computable Incentive Amount:			$ -
Total Sum of Achievement Values:			-
Total Number of Milestones:			-
Achievement Value Percentage:			
Eligible Incentive Funding Amount:			
Incentive Funding Already Received in DY:			$ -
Incentive Payment Amount:			

Category 4 Summary Page

Venous Thromboembolism (VTE) Prevention and Treatment

Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ -
Total Sum of Achievement Values:	-
Total Number of Milestones:	-
Achievement Value Percentage:	
Eligible Incentive Funding Amount:	
Incentive Funding Already Received in DY:	$ -
Incentive Payment Amount:	

Category 4 Summary Page

Falls with Injury Prevention	
Prevalence of patient falls with injuries (Rate per 1,000 patient days)	N/A
Achievement Value	
Optional Milestone: -	N/A
Achievement Value	
Optional Milestone: -	N/A
Achievement Value	
Optional Milestone: -	N/A
Achievement Value	
Optional Milestone: -	N/A
Achievement Value	
Optional Milestone: -	N/A
Achievement Value	
Optional Milestone: -	N/A
Achievement Value	
DY Total Computable Incentive Amount:	$ -
Total Sum of Achievement Values:	-
Total Number of Milestones:	-
Achievement Value Percentage:	
Eligible Incentive Funding Amount:	
Incentive Funding Already Received in DY:	$ -
Incentive Payment Amount:	

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * | Yes |

Category 1: Expand Primary Care Capacity

Below is the data reported for the DPH system.
Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes', please type in all of your DY milestones for the project below and report data in the indicated boxes (*).

* ☐ The yellow boxes indicate where the DPH system should input data

☐ The black boxes indicate Milestones and will automatically populate and flow to summary sheets

☐ The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically populate and flow to summary sheets

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Expand Primary Care Capacity

DY Total Computable Incentive Amount: * | $ 18,500,000.00 |

Incentive Funding Already Received in DY: * | $ 18,500,000.00 |

Process Milestone: 1. Maintain the Office of Panel Management, such that panel capacity is continuously optimized. Develop a plan for scoring paneled patients for complexity

(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 |

The Office of Panel Management was maintained during DY 7 and expanded its work to evaluate and implement practices at SCVMC to continuously optimize panel capacity. The Office of Panel Management is led by the Director of Panel Management and its processes are implemented and maintained by a full-time Panel Management analyst and two full-time Panel Coordinators. The Office of Panel Management is guided by the Panel Management Committee which is comprised of Ambulatory Administration and physician leadership. During DY 7, the Panel Management Committee met bi-weekly to address problems, identify, test, and evaluate panel management interventions. Its membership includes:

• The Director of Panel Management
• Panel Management Analyst
• Chief of Primary Care Medicine
• Primary Care Physician
• Director of Ambulatory & Community Health Services
• Valley Heath Plan Medical Director
• Ad hoc members as needed

During DY 7 the Office of Panel Management, in conjunction with the Panel Management Committee, started or completed the following interventions:

• Through data and analysis, identified our panel capacity limitations, demand and sizes.
• Recognized that there are limitations to the number of patients and services each provider can effectively provide.
• Produced monthly panel reports for each Primary Care Physician (PCP) and an Executive Summary which includes a list of all patients paneled to the PCP as of the reporting month and patients dropped, added, and transferred. The report serves as a panel management tool for PCPS and is also used by Administration to assign patients to panels and monitor panel capacity.
• Reviewed monthly the panel capacity of each PCP via the monthly panel report and acted upon this information to open or close individual PCP panels. This allowed SCMVC to improve our ability to detect over-paneling and proactively manage known patient attrition over time.
• Changed the length of a time inactive (defined as no applicable primary care visits) non-managed care patients remain paneled to 18 months in order to increase capacity for new patients. Previous to this patients with no activity remained paneled for two years.
• Developed and implemented a process to send letters to inactive, non-managed care patients after 14 months of applicable primary care inactivity. The letter informs them that they are nearing the drop period and encourages

DSRIP Semi-Annual Reporting Form

Category 1: Expand Primary Care Capacity

them to schedule an appointment with their primary care provider.

• Researched, tested, and adopted a tool for complexity scoring of paneled patients. The Panel Committee researched and tested several industry standard models including the Mark Murray Model and the Denver Health Model. SCVMC also created and tested an internally developed model. After applying each of these models to our panels and evaluating the complexity and merit of each, the Denver Model was selected as our complexity scoring model. This model was selected because it was designed by a public hospital with similar patient and institutional attributes, and the Panel Committee determined it most accurately reflected our patient complexity. The Denver model uses a mix of age and gender to approximate complexity.

SCVMC realizes that while continuously optimizing panel capacity is essential for Health Care Reform in 2014, it is only part of a much broader set of interventions that must be employed to reach readiness. Other intricately connected interventions such as expanding clinic hours, increasing the number of available appointments, and monitoring the availability of appointments are described in subsequent milestones.

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

Process Milestone:	2. Increase primary care clinic volume. Hire additional primary care providers and support staff to increase primary care adult medicine panel capacity to 46,000 patients.

(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

During DY 7 SCVMC met or exceeded our goals to increase primary care clinic volume, hireed additional primary care providers and support staff, and increase adult medicine panel capacity to 46,000 patients.

Specifically, the following achievements were realized:

• Primary care clinic visits increased from 103,039 to 116,506 for the period of FY 11 to FY 12, which is commensurate with DSRIP years DY 6 and 7 respectively.
• As of June 30, 2012, our adult medicine panel capacity is 49,421. At the time of this report, SCVMC had 48,101 adult primary care patients paneled and 2,317 panel slots available to new patients. Combined, these figures exceed the 49,421 capacity and this is due to the historical over paneling of several providers, which is being carefully monitored and managed as we move forward.
• During DY 7, SCMVC hired 4 new MDs and medical assistant support staff resulting in a net increase of 9.3 clinical half-days per week from the previous year, and a corresponding increase in capacity for newly paneled patients.

The documented increase in panel capacity is largely due to the outcome of the interventions deployed by the Office of Panel Management, many of which are described in the preceding milestone. In addition the following occurred during DY 7:

• Hired 4 additional primary care providers and associated support staff
• Expanded express care clinic hours at two adult primary care clinic locations (see Milestone 5 for details), which resulted in a gain of 32 hours of clinical time available for patient care.
• Standardized scheduling templates for PCPs and increased our standard for number of patients seen per half day.
• Standardized the time off request process for PCPs in a manner that ensures sufficient availability of primary care providers.

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

DSRIP Semi-Annual Reporting Form

Category 1: Expand Primary Care Capacity

Process Milestone:	3. Develop a plan and gain approval to design and construct an additional 60,000 sq. foot primary care clinic in the underserved downtown San Jose urban core.

(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

History: SCVMC governing board has approved the building of an additional 60, 000 sq. foot primary care clinic in the underserved downtown San Jose urban area to meet the medical needs of thousands who presently live in the downtown area of San Jose. We recognized that the number of uninsured and underserved continues to increase as more citizens lose their health care coverage; many others who comprise the working poor cannot afford the high cost of healthcare in the private sector. Our aim is to reach those who need medical care in the downtown San Jose urban area.

The SCVMC governing board approved the building project; the drawings for the new clinic were submitted to the Building Department in mid-January, 2012. We have met with the Building Department to get a preliminary review of our occupant load and exiting scheme for the new clinic. Due to recent changes to the building code, the Building Department is requiring that we provide low walls (36" high) to separate the waiting areas from the registration areas on the second and third floors. Ratcliff, the builder, has reviewed these changes, and we do not think it is going to be difficult to implement.

During the second half of DY 7, a request for proposal was issued and multiple bids were received by the County during the early summer. Currently, these bids are under review and we expect an award to be issued in October 2012. As of the end of this reporting report, construction is expected to begin in late Fall 2012.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * Yes

    Achievement Value   1.00

Process Milestone:	4. Implement a system to accommodate urgent care needs in at least two primary care clinics, as measured by achieving at least 20% of paneled patients scheduled within 7 calendar days.

(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

SCVMC hired additional PCPs and support staff and established Express Care services at two primary care clinics – Valley Health Center at Tully and Valley Health Center at Gilroy. Staff has been assigned to cover and support this service to accommodate patients' urgent care needs. Express Care provider schedules are only opened 24/48 hours in advance of the appointment to ensure same and next day appointments slots are available to patients. As of June 30, 2012, the 3rd available appointment for Adult Express Care was on average one day, with multiple locations at zero days. The number of Express Care half days, hours, and the third available appointment time is reported and filed monthly.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * Yes

    Achievement Value   1.00

Process Milestone:	5. Expand the hours of at least two primary care clinics by at least 16 hours per week.

(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

Category 1: Expand Primary Care Capacity

During DY 7, SCVMC met its goal to expand the hours of at least two primary care clinics by a minimum of 16 hours per week. This was achieved through the following clinic hour expansions:

• Valley Health Center at Sunnyvale added four hours per day X 4 days/week.
• Valley Health Center at Tully added four hours per day X 4 days/week

These combined expanded hours add up to 32 additional hours per week in which adult primary care patients can access clinical services at SCVMC. The increase in primary care clinic hours is evidenced by clinic schedules.

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

Category 1: Expand Primary Care Capacity

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * ▯

Denominator (if absolute number, enter "1")   * ▯

Achievement   [N/A]

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: * ▯

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * ▯

Achievement Value   [▯]

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * ▯

Denominator (if absolute number, enter "1")   * ▯

Achievement   [N/A]

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: * ▯

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * ▯

Achievement Value   [▯]

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * ▯

Denominator (if absolute number, enter "1")   * ▯

Achievement   [N/A]

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: * ▯

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * ▯

Achievement Value   [▯]

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Category 1: Expand Primary Care Capacity

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [ ]

Denominator (if absolute number, enter "1")   * [ ]

Achievement   [N/A]

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: * [ ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [ ]

Achievement Value   [ ]

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [ ]

Denominator (if absolute number, enter "1")   * [ ]

Achievement   [N/A]

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: * [ ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [ ]

Achievement Value   [ ]

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: *

Category 1: Increase Training of Primary Care Workforce

Below is the data reported for the DPH system.
*Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).*

* ☐ The yellow boxes indicate where the DPH system should input data
☐ The black boxes indicate Milestones and will automatically populate and flow to summary sheets
☐ The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
populate and flow to summary sheets

Increase Training of Primary Care Workforce

DY Total Computable Incentive Amount: *

Incentive Funding Already Received in DY: *

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   N/A

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: *

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

   Achievement Value

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   N/A

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: *

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

   Achievement Value

DSRIP Semi-Annual Reporting Form

Category 1: Increase Training of Primary Care Workforce

Process Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

   Achievement | N/A |

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: *

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

   Achievement Value

Process Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

   Achievement | N/A |

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: *

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

   Achievement Value

Process Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

   Achievement | N/A |

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: *

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

   Achievement Value

DSRIP Semi-Annual Reporting Form

Category 1: Increase Training of Primary Care Workforce

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *[   ]

Denominator (if absolute number, enter "1")   *[   ]

  Achievement   [N/A]

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: *[   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   *[   ]

  Achievement Value   [   ]

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *[   ]

Denominator (if absolute number, enter "1")   *[   ]

  Achievement   [N/A]

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: *[   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   *[   ]

  Achievement Value   [   ]

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *[   ]

Denominator (if absolute number, enter "1")   *[   ]

  Achievement   [N/A]

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: *[   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   *[   ]

  Achievement Value   [   ]

Category 1: Increase Training of Primary Care Workforce

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * ▢

Denominator (if absolute number, enter "1")   * ▢

    Achievement   N/A

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: * ▢

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * ▢

    Achievement Value

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * ▢

Denominator (if absolute number, enter "1")   * ▢

    Achievement   N/A

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: * ▢

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * ▢

    Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * | Yes |

Category 1: Implement and Utilize Disease Management Registry Functionality

Below is the data reported for the DPH system.
 *Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).*
* ☐ The yellow boxes indicate where the DPH system should input data
☐ The black boxes indicate Milestones and will automatically populate and flow to summary sheets
☐ The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
   populate and flow to summary sheets

Implement and Utilize Disease Management Registry Functionality

DY Total Computable Incentive Amount: * | $ 18,500,000.00 |

Incentive Funding Already Received in DY: * | $ 10,791,666.67 |

Process Milestone: 1. Review future potential registry platforms and select registry platform.
                          (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 |

> A review of available registry platforms was conducted, which included site visits to local agencies using the products. A list of possible and desired registry features was developed, focusing on input from clinicians. A detailed request for proposals (RFP) was released on Sept. 15, 2010. The RFP asked for proposals from qualified suppliers to provide, install, implement, customize, support and maintain a software solution for a Population Health Management System.
>
> The RFP overview states: "The County's intent is to implement a 'Population Health Management System' (PHMS). This hybrid application is a fusion of the best of patient registry technology that collects and analyze chronic disease measures from multiple sources via standard Interfaces but has extended capability for outreach and provider communications.
>
> The evolving model of a PHMS has an appropriately-sized data warehouse at its foundation for the registry and reporting. This data warehouse is then bi-directionally integrated to an outreach-engine/tool set. The systemic approach of Population Health Management practices provides data collection, sophisticated warehousing, and alysis/research/reporting which allow health care systems analysts to build second order derived data that is used for follow-up provider /clinic outreach to individual patients, special cohorts and entire populations. This cycle is continually re-informed by capturing the outcomes from patient data posted in the Electronic Medical Record (EMR), the enterprise Health Information System (HIS), the Lifetime Clinical Record (LCR) and routing them back to the Population Health Systems (PHMS) data warehouse.
>
> Population Health Management, software, workflow templates, data structures with supporting technology are emerging as integrated solutions to improve patient care from what is learned from the chronic disease registries. The real advancement the County is seeking in this RFP is strong analytical tools woven into a bi-directional data flow to and from the PHMS and all of the reporting systems."
>
> Proposals were received from two vendors, and Health Metrics Systems was selected. The contract was signed on August 29, 2011.
>
> See Milestone 1-2-2 for a description of why we terminated the Health Metrics Systems contract for convenience in March 2012.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * | Yes |

   Achievement Value | 1.00 |

Process Milestone: 2. Implement/expand a functional disease registry in at least 25% (2 out of 7) of medical home teams.
                          (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * | |

Denominator (if absolute number, enter "1")   * | |

DSRIP Semi-Annual Reporting Form

Category 1: Implement and Utilize Disease Management Registry Functionality

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

From July 2011 through June 30, 2012, the Filemaker-based Population Health Management System (PHMS), formerly called "Chronic Disease Registry", was used by clinicians and Care Managers, primarily in medical homes in Milpitas, Sunnyvale, and Moorpark.

Preliminary work for implementation of Health Metrics Systems software "Solutions for Quality Improvement" began in September 2011. From September through November, 2011 there were 681 contacts/invitations to PHMS meetings, with 165 individuals. There were presentations and discussions at the Executive Management Group, the Executive Leadership Group, and the Readiness Action Group. Separate presentations, product demo trainings and interviews also were held with clinicians in each of the following groups: pediatric asthma, anti-coagulation, heart failure, pediatric obesity, adult diabetes, ophthalmology, pediatric nephrology, primary clinics in the community, ambulatory care, labs, pharmacy, and public health. Data source and data harvesting meetings were held with systems owners and analysts. Technical meetings with networking and operations were held to set up the servers' security to the cloud, to establish Memorandum of Understanding (MOU), and to automatically collect data from other servers to the PHMS collection server. In short, there were meetings to refine and prioritize clinician needs to determine data needs and best sources, to garner permissions to collect data and load into the PHMS collection server, and to secure those data connections.

Based on the meetings with executive, clinicians and data system owners, the Health Metrics Systems CEO presented his report of recommended prioritized source systems and implementation timeline to the Executive Management Group on Oct. 10, 2011. The vendor's planned timeline was aligned with the overall population health project timeline.

On Feb. 15, 2012, Valley Medical Center learned details of EPIC's (Electronic health records system) newly-developed chronic disease and wellness registries, which are included in the EPIC license. There will be 24 registries in Epic/HealthLink. Because of these anticipated Epic registries, we terminated the Health Metrics Systems contract for convenience in March 2012, including registries for diabetes, asthma, and wellness.

From February through June 2012, the PHMS system plans changed because Santa Clara County Valley Medical Center began to plan for implementing Epic. (EPIC is called "HealthLink" at SCVMC.) SCVMC expects HealthLink to be live in May 2013. The EPIC registries will allow clinicians to have registries and the electronic medical record available in the same EPIC system. Currently, clinicians have to use several separate systems to access electronic medical records, labs, the Filemaker-based PMS, etc. One advantage of the existing PMS is that it sources data from a variety of systems, making it easy to see the key indicators of a diabetic patient in one system. Although the official EMR is the source of information for making treatment decisions, PHMS provides a time-saving quick overview of patient panels and drills down to an individual patient's chronic disease key indicators.

In March, 2012, after terminating the registry vendor contract, we modified the PHMS (the "registry") implementation plan to use a combination of Filemaker server and SQL server applications. This complex, extensive FilemakerPro-based registry will be used in DY8 while we consider the registry tools that will be available in HealthLink beginning in May 2013.

During this second half of DY7, PHMS focused on:
- Increasing access to PHMS by increasing the number of client licenses from 50 to 100 user licenses.
- Increasing PHMS system speed so that when clinicians run reports they will not have to wait long for the report to appear. To increase system speed, pre-indexed canned reports were developed. The three areas of canned reports that clinicians identified for immediate work:
    - all diabetic patients without retinal exam in the last two years
    - all diabetic patients without LDL exam in the last year
    - all diabetic patients without A1C screening in the last year
- Increase the number of data feeds. Establish data feeds to obtain ICD-9 codes, CPT, and EWS patient scheduling information (including appointments scheduled in the future).
- Enhance PHMS data features. PHMS staff improved Pharmacy data available in PHMS by including drug classification/type for easier reporting. For example, report all those diabetic patients who take a statin drug, without needed to list all the names of statin drugs.
- Increase frequency of data refreshes in PHMS. Prior to DY7, reports of paneled patients (List of assigned patients to physicians) was released monthly, and processed in PHMS only quarterly because of lack of staff. Prior to DY7, when Care Managers or clinicians looked at PHMS reports, the patient panel was out of date by up to 3 months. In the second half of DY7, the monthly report was processed monthly when received. In addition, the report that contains patient biographical and demographic information was only refreshed quarterly and by the end of DY7 was processed monthly. The Lifetime A1c values were updated quarterly prior to DY7, and are now processed monthly (other lab results are received and processed daily).

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone | * Yes

Achievement Value | 1.00

Category 1: Implement and Utilize Disease Management Registry Functionality

Process Milestone:	3. Conduct training on registry platform for relevant staff members in at least 25% (2 out of 7) of medical home teams.

(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]

As mentioned in milestone 1-2-2, the plan was to use PHMS in Milpitas and Gilroy first. Then in December, the decision was made to implement in two Medical Homes in Moorpark clinics. In October 2011, when we had a contract with Health Metrics Systems, the vendor conducted Level I one-hour trainings for 168 participants. That training was the demonstration and presentation of the product. The Level II training (two hours) was accomplished through data management and data use meetings with the medical director of the Milpitas Clinic and the medical director of the Diabetes Clinic.

After the contract with the vendor was terminated, and the decision was made to enhance the Filemaker-based registry as a bridge strategy to HealthLink, the strategy changed to increasing access to the Filemaker-based PHMS registry. Rather than focusing on training at two clinics, the training was broader to include more clinics/medical home teams. A user support process was developed, including an online service request form, and some self-help questions and answers.

In March 2012, we began enhancing the existing Filemaker PHMS based on feedback from the clinicians. On May 8, 2012, a one-hour training was held for Care Managers and clinicians covering this outline of PHMS enhancements:

Diabetic Care Manager Training May 8th – Registry Enhancements
1. Update on Registry
2. Enhancements
    a. Increased frequency of data refreshes
    b. Expanded Access
    c. Quick Reports - Training
3. How to share your feedback with us
4. What's next?

On June 16, 2012, a detailed step-by-step training was delivered to the 30 Care Managers, Medical Assistants, Physicians, Nurses and health service representatives (HSRs) in the diabetes clinic and medical homes. The participants were from clinics/ medical homes at Gilroy, Moorpark, Sunnyvale, Tully, as well as the VMC Diabetes Clinic. Here is the training outline:

Training Agenda for Beginning PHMS (Filemaker) Users
Desired Outcomes
By the end of the training (classroom + one follow up session) participants will:
    1. Understand what a registry is and how it supports population management.
    2. Understand the SCVMC registry, the sources of data it contains, and the specific tools for Diabetic Care Managers and Medical Assistants.
    3. Be able to use the SCVMC registry to perform the following tasks:
        a. Access the Diabetes template, review patient history, and enter a new patient
        b. Enter outside labs, eye exams, and medications
        c. Enter a patient expiration
        d. Utilize quick reports to identify groups of patients in need of screening, including printing the report, and performing basic functions in Excel to manipulate the data.
    4. Know how to get additional support when needed.

At the June 16, 2012 training, participants completed a self assessment form about their level of proficiency using the registry. The results were as follows:

Beginning 20 participants
Moderate   9 participants
Proficient   1 participant

On the form, participants were asked, "Would you like an onsite follow up training (beginners only)?"
Fourteen of the 20 "beginning-level" participants indicated they wanted the follow up training, and they received that follow up training.

The effectiveness of the new user training in DY 7 was evaluated by reviewing the trainees use of the system (as evidenced by access logs for the various reports in the registry) and by post training individual follow-up sessions. During these sessions, the trainer sat with identified new users and checked for understanding and competence by asking the

DSRIP Semi-Annual Reporting Form

Category 1: Implement and Utilize Disease Management Registry Functionality

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone | * | Yes

Achievement Value | 1.00

Process Milestone: 4. Demonstrate registry reporting ability to track and report on at least 2 selected metrics.

(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

The Filemaker-based Chronic Disease Registry includes regular data refreshes from labs (including comments/modifiers), pharmacy prescriptions written and filled at HHS, "ELMR" the current electronic medical record in the clinics, diabetes clinic, urgent care, emergency dept, hospital discharge, hospital census, PCP panel list, Care Manager list, appointment data, BMI, eye exams, ICD9, and CPT codes. Also, the diabetes roster, and the geriatric roster are loaded monthly when they are available.

The reporting in DY7 has focused on key indicators, including A1c and LDL results. Reporting has been expanded substantially, to the point that now over 1500 reports are available to clinicians and care managers in PHMS.

In the second half of DY7, and continuing on into DY8, we are systematically validating data both intra-system, and inter-system, comparing results in PHMS with other systems such as Invision (Inpatient data system). In short, we are verifying that the data in PHMS are correct and complete. Because of this validation effort, we learned that prior to April 2012, about 10% of diabetics were not identified in PHMS, when compared to measures from other VMC systems. At SCVMC, any patient who has ever had an A1c equal to or greater than 6.5 is defined as diabetic. The problem was caused in part by the method used to request lab results. Prior to April 2012, PHMS sent a list of MRNs to the lab system administrator. Labs would return a file with lab results for those requested MRNs only. If someone were defined as diabetic later, the previous test results would not be in PHMS since it is a data warehouse or data mart, not a complete repository of lab results. Hence, previous lab results might be missed. Then if a Care Manager found a patient's LDL lab results in ClinWeb, but did not find those same LDL tests in PHMS, the Care Manager could lose confidence in the PHMS data. In DY7, a memorandum of understanding (MOU) between SCVMC laboratory, Ambulatory Care and HHS-Information Services was developed and approved by all parties. This represents a level of increased trust and collaboration across the organizations. In DY7, labs agreed to send all lab results for patients, where the lab test was ordered by a SCVMC clinician. By increasing the data quality and improving trust, the PHMS system is expanding and improved reporting.

In spring 2012, and continuing in DY8, we are systematically testing reporting functions in PHMS to see if they are working as expected from the clinicians' perspective. We are defining a process where issues are discussed and resolved.

In addition to the reports that clinicians can generate for themselves in PHMS, the system sends daily reports to PCPs on the state of their paneled patients (including diabetics), and periodic special reports for diabetes clinicians.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone | * | Yes

Achievement Value | 1.00

Process Milestone: 5. Enter patient data into the registry - interface at least 2 data categories or sources to registry for adult primary care clinic patients.

(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

The data source feeds have been established. There are 876K patients in the new PHMS registry. The remaining data issues deal with best data field(s) for information, such as foot exams, which can be entered in the source files in more than one location.

The PHMS server was implemented on site, with a secure network from HHS to a vendor-hosted cloud service, and secure connections for users with a web interface to the cloud service.

The EWS scheduling system and the Decision Support System (for patient demographics) have established ODBC connections so that the PHMS Collection server can automatically login to those data source servers, run a script

Category 1: Implement and Utilize Disease Management Registry Functionality

(approved by the system owner), collect the data, and logout.

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

DSRIP Semi-Annual Reporting Form

Category 1: Implement and Utilize Disease Management Registry Functionality

Improvement Milestone: 6. Implement and staff cross-functional team to develop and operate registry program.

(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`

The staffing functions were identified, which included staff from the clinical side, support from IT, and administrators who are data source owners.

Under the executive leadership, there has been extraordinary cooperation between the clinicians, the data source owners, and PHMS staff. SCVMC wants PHMS to have a positive impact on patients with chronic diseases. The roles of Care Managers and others on the clinical side as well as those on the technical side were identified and recognized. However, there have been many changes in personnel, in part due to beginning the EPIC/HealthLink (Electmic health records system) implementation where an implementation team of about 90 staff was formed. Despite these organizational changes, PHMS implementation and enhancement has succeeded.

Executive and Clinical Leadership on PHMS team
- The PHMS Executive Sponsor and business owner is the Ambulatory Care Director.
- The Medical Director, Ambulatory Care, oversees clinical decisions and direction. The Director left SCVHHS on March 2, 2012. Executive Director, Ambulatory Care and Managed Care Services, filled in as PHMS Ambulatory Care lead from March through May, 2012. In June 2012, the Ambulatory Director took on the leadership responsibility (as well as maintaining the executive-level sponsorship). As of June 30, 2012, Ambulatory Care was actively recruiting for the Chronic Care Medical Director.
- The Director, Center for Diabetes and Metabolism and his team of 30 Care Managers and other staff are the main champions of PHMS. They work in medical homes and at the VMC Diabetes Clinic. They request new functionality, report issues, and actively use PHMS to achieve their patient care targets.
- Director of Primary Care at VMC, and long-term head of the Milpitas Clinic, including the medical homes there. She and her staff support and actively use PHMS.
- There was a DSRIP quality clinical group led by the Medical Director to discuss processes for establishing registries and populations in PHMS, and discussion of that group evolving into a clinical advisory group. After he left SCVMC in March 2012, we delayed establishing the clinical advisory team until the new Ambulatory Care Medical Director's ("Chronic Care Director") is hired. Meanwhile, Director , Center for Diabetes and Metabolism, and Director of Primary Care have served the function of a quality clinical advisory team.

Technical members of PHMS team

Four staff positions are assigned full-time to PHMS:
- PHMS Project Manager since Sept. 2011, the project manager role has been filled with an interim project manager (on loan from central IT) who has background in IT and public health. As of June 30, 2011, recruitment was in progress for someone with IT and health care experience who can manage the project.
- Database administrator (DBA) SQL specialist. from July 1 through March 2012, the DBA position was filled until the staff member joined the HealthLink implementation group. Since we changed course away from the vendor's SQL solution in February 2012, not having the SQL specialist on board has not been as impactful as it would have been had we maintained the HMS vendor contract. The Filemaker-based PHMS uses a SQL Collection Server where source data accumulates daily. The employee who joined the HealthLink implementation group is available to us for quick questions and advice. As of June 30, 2012, recruiting for the SQL specialist is in progress.
- System Administrator Filemaker specialist throughout DY7. This position has been filled by the same Filemaker specialist.
- Ambulatory Care specialist to liaison between clinicians and IT, and to train clinical staff. We had initially planned to hire a data analyst in this role. However, in the first half of DY7 while implementing the HMS vendor registry, there was not much data to analyze. In January 2012, Ambulatory Care suggested using an existing long-time

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   `*` `Yes`

   Achievement Value   `1.00`

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   `*` [ ]

Denominator (if absolute number, enter "1")   `*` [ ]

   Achievement   `N/A`

Category 1: Implement and Utilize Disease Management Registry Functionality

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:

*

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

Achievement Value

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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:

*

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

Achievement Value

DSRIP Semi-Annual Reporting Form

Category 1: Implement and Utilize Disease Management Registry Functionality

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

  Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

  Achievement Value   [   ]

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

  Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

  Achievement Value   [   ]

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: *

Category 1: Enhance Interpretation Services and Culturally Competent Care

Below is the data reported for the DPH system.
Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).

* ☐ The yellow boxes indicate where the DPH system should input data
  ☐ The black boxes indicate Milestones and will automatically populate and flow to summary sheets
  ☐ The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
  populate and flow to summary sheets

Enhance Interpretation Services and Culturally Competent Care

DY Total Computable Incentive Amount: *

Incentive Funding Already Received in DY: *

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   N/A

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: *

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

   Achievement Value

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   N/A

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: *

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

   Achievement Value

Category 1: Enhance Interpretation Services and Culturally Competent Care

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * ☐

Denominator (if absolute number, enter "1")   * ☐

Achievement   N/A

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: * ☐

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * ☐

Achievement Value

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * ☐

Denominator (if absolute number, enter "1")   * ☐

Achievement   N/A

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: * ☐

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * ☐

Achievement Value

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * ☐

Denominator (if absolute number, enter "1")   * ☐

Achievement   N/A

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: * ☐

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * ☐

Achievement Value

DSRIP Semi-Annual Reporting Form

Category 1: Enhance Interpretation Services and Culturally Competent Care

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   N/A

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: *

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

   Achievement Value

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   N/A

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: *

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

   Achievement Value

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   N/A

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: *

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

   Achievement Value

Category 1: Enhance Interpretation Services and Culturally Competent Care

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * [   ]

Category 1: Collect Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities

Below is the data reported for the DPH system.
*Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).*
* [ ] The yellow boxes indicate where the DPH system should input data
[ ] The black boxes indicate Milestones and will automatically populate and flow to summary sheets
[ ] The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
populate and flow to summary sheets

Collect Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities

DY Total Computable Incentive Amount: * [   ]

Incentive Funding Already Received in DY: * [   ]

Process Milestone: _____
                                    (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

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

Process Milestone: _____
                                    (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

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

DSRIP Semi-Annual Reporting Form

Category 1: Collect Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

DSRIP Semi-Annual Reporting Form

Category 1: Collect Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

DSRIP Semi-Annual Reporting Form

Category 1: Collect Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *[ ]

Denominator (if absolute number, enter "1")   *[ ]

Achievement   [N/A]

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: *[ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   *[ ]

Achievement Value   [ ]

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *[ ]

Denominator (if absolute number, enter "1")   *[ ]

Achievement   [N/A]

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: *[ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   *[ ]

Achievement Value   [ ]

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * [   ]

Category 1: Enhance Urgent Medical Advice

Below is the data reported for the DPH system.
*Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).*

* [ ] The yellow boxes indicate where the DPH system should input data
[ ] The black boxes indicate Milestones and will automatically populate and flow to summary sheets
[ ] The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically populate and flow to summary sheets

Enhance Urgent Medical Advice

DY Total Computable Incentive Amount: * [   ]

Incentive Funding Already Received in DY: * [   ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

DSRIP Semi-Annual Reporting Form

Category 1: Enhance Urgent Medical Advice

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [ ]

Denominator (if absolute number, enter "1")   * [ ]

    Achievement   [N/A]

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: * [ ]

[ ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [ ]

    Achievement Value   [ ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [ ]

Denominator (if absolute number, enter "1")   * [ ]

    Achievement   [N/A]

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: * [ ]

[ ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [ ]

    Achievement Value   [ ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [ ]

Denominator (if absolute number, enter "1")   * [ ]

    Achievement   [N/A]

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: * [ ]

[ ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [ ]

    Achievement Value   [ ]

DSRIP Semi-Annual Reporting Form

Category 1: Enhance Urgent Medical Advice

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) `*`

Denominator (if absolute number, enter "1") `*`

Achievement | N/A |

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: `*`

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone `*`

Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) `*`

Denominator (if absolute number, enter "1") `*`

Achievement | N/A |

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: `*`

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone `*`

Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) `*`

Denominator (if absolute number, enter "1") `*`

Achievement | N/A |

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: `*`

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone `*`

Achievement Value

DSRIP Semi-Annual Reporting Form

Category 1: Enhance Urgent Medical Advice

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * [   ]

Category 1: Introduce Telemedicine

Below is the data reported for the DPH system.
*Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).*
* [ ] The yellow boxes indicate where the DPH system should input data
[ ] The black boxes indicate Milestones and will automatically populate and flow to summary sheets
[ ] The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
populate and flow to summary sheets

Introduce Telemedicine

DY Total Computable Incentive Amount: * [   ]

Incentive Funding Already Received in DY: * [   ]

Process Milestone: _____
                                        (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

Process Milestone: _____
                                        (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

DSRIP Semi-Annual Reporting Form

Category 1: Introduce Telemedicine

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   N/A

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: *

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

   Achievement Value

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   N/A

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: *

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

   Achievement Value

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   N/A

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: *

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

   Achievement Value

DSRIP Semi-Annual Reporting Form

Category 1: Introduce Telemedicine

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   `N/A`

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: *

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

   Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   `N/A`

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: *

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

   Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   `N/A`

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: *

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

   Achievement Value

DSRIP Semi-Annual Reporting Form

Category 1: Introduce Telemedicine

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   N/A

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: *

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

   Achievement Value

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   N/A

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: *

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

   Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * [   ]

Category 1: Enhance Coding and Documentation for Quality Data

Below is the data reported for the DPH system.
Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).
* ☐ The yellow boxes indicate where the DPH system should input data
   ☐ The black boxes indicate Milestones and will automatically populate and flow to summary sheets
   ☐ The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
   populate and flow to summary sheets

Enhance Coding and Documentation for Quality Data

DY Total Computable Incentive Amount: * [   ]

Incentive Funding Already Received in DY: * [   ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

  Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

   Achievement Value   [   ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

  Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

   Achievement Value   [   ]

DSRIP Semi-Annual Reporting Form

Category 1: Enhance Coding and Documentation for Quality Data

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   `*` [ ]

Denominator (if absolute number, enter "1")   `*` [ ]

    Achievement   [N/A]

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: `*` [ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   `*` [ ]

    Achievement Value   [ ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   `*` [ ]

Denominator (if absolute number, enter "1")   `*` [ ]

    Achievement   [N/A]

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: `*` [ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   `*` [ ]

    Achievement Value   [ ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   `*` [ ]

Denominator (if absolute number, enter "1")   `*` [ ]

    Achievement   [N/A]

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: `*` [ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   `*` [ ]

    Achievement Value   [ ]

DSRIP Semi-Annual Reporting Form

Category 1: Enhance Coding and Documentation for Quality Data

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   `*` [ ]

Denominator (if absolute number, enter "1")   `*` [ ]

  Achievement   [N/A]

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: `*` [ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   `*` [ ]

  Achievement Value   [ ]

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   `*` [ ]

Denominator (if absolute number, enter "1")   `*` [ ]

  Achievement   [N/A]

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: `*` [ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   `*` [ ]

  Achievement Value   [ ]

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   `*` [ ]

Denominator (if absolute number, enter "1")   `*` [ ]

  Achievement   [N/A]

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: `*` [ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   `*` [ ]

  Achievement Value   [ ]

Category 1: Enhance Coding and Documentation for Quality Data

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement | N/A |

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: *

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

Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement | N/A |

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: *

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

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * [_____]

Category 1: Develop Risk Stratification Capabilities/Functionalities

Below is the data reported for the DPH system.
*Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).*
* □ The yellow boxes indicate where the DPH system should input data
■ The black boxes indicate Milestones and will automatically populate and flow to summary sheets
□ The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
   populate and flow to summary sheets

Develop Risk Stratification Capabilities/Functionalities

DY Total Computable Incentive Amount: * [_____]

Incentive Funding Already Received in DY: * [_____]

Process Milestone: _____
                           (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * [_____]

Denominator (if absolute number, enter "1") * [_____]

   Achievement   [N/A]

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: * [_____]

[ ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [_____]

   Achievement Value   [_____]

Process Milestone: _____
                           (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * [_____]

Denominator (if absolute number, enter "1") * [_____]

   Achievement   [N/A]

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: * [_____]

[ ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [_____]

   Achievement Value   [_____]

Category 1: Develop Risk Stratification Capabilities/Functionalities

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *[ ]

Denominator (if absolute number, enter "1") *[ ]

Achievement [N/A]

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: *[ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone *[ ]

Achievement Value [ ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *[ ]

Denominator (if absolute number, enter "1") *[ ]

Achievement [N/A]

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: *[ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone *[ ]

Achievement Value [ ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *[ ]

Denominator (if absolute number, enter "1") *[ ]

Achievement [N/A]

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: *[ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone *[ ]

Achievement Value [ ]

DSRIP Semi-Annual Reporting Form

Category 1: Develop Risk Stratification Capabilities/Functionalities

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [ ]

Denominator (if absolute number, enter "1")   * [ ]

Achievement   [N/A]

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: * [ ]

[ ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [ ]

Achievement Value   [ ]

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [ ]

Denominator (if absolute number, enter "1")   * [ ]

Achievement   [N/A]

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: * [ ]

[ ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [ ]

Achievement Value   [ ]

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [ ]

Denominator (if absolute number, enter "1")   * [ ]

Achievement   [N/A]

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: * [ ]

[ ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [ ]

Achievement Value   [ ]

DSRIP Semi-Annual Reporting Form

Category 1: Develop Risk Stratification Capabilities/Functionalities

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   `N/A`

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: *

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

   Achievement Value

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   `N/A`

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: *

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

   Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: *[   ]

Category 1: Expand Specialty Care Capacity

Below is the data reported for the DPH system.
 * Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).
 *[ ] The yellow boxes indicate where the DPH system should input data
 [ ] The black boxes indicate Milestones and will automatically populate and flow to summary sheets
 [ ] The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
     populate and flow to summary sheets

Expand Specialty Care Capacity

DY Total Computable Incentive Amount: *[   ]

Incentive Funding Already Received in DY: *[   ]

Process Milestone: _____
                                    (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *[   ]

Denominator (if absolute number, enter "1")   *[   ]

   Achievement   [N/A]

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: *[   ]

[   ]

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

Process Milestone: _____
                                    (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *[   ]

Denominator (if absolute number, enter "1")   *[   ]

   Achievement   [N/A]

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: *[   ]

[   ]

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

Category 1: Expand Specialty Care Capacity

Process Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * [ ]

Denominator (if absolute number, enter "1") * [ ]

   Achievement [N/A]

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: * [ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [ ]

   Achievement Value [ ]

Process Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * [ ]

Denominator (if absolute number, enter "1") * [ ]

   Achievement [N/A]

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: * [ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [ ]

   Achievement Value [ ]

Process Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * [ ]

Denominator (if absolute number, enter "1") * [ ]

   Achievement [N/A]

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: * [ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [ ]

   Achievement Value [ ]

DSRIP Semi-Annual Reporting Form

Category 1: Expand Specialty Care Capacity

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * [ ]

Denominator (if absolute number, enter "1") * [ ]

Achievement [N/A]

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: * [ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [ ]

Achievement Value [ ]

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * [ ]

Denominator (if absolute number, enter "1") * [ ]

Achievement [N/A]

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: * [ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [ ]

Achievement Value [ ]

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * [ ]

Denominator (if absolute number, enter "1") * [ ]

Achievement [N/A]

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: * [ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [ ]

Achievement Value [ ]

DSRIP Semi-Annual Reporting Form

Category 1: Expand Specialty Care Capacity

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   `N/A`

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: *

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

   Achievement Value

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   `N/A`

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: *

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

   Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: *

Category 1: Enhance Performance Improvement and Reporting Capacity

Below is the data reported for the DPH system.
*Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).*
* The yellow boxes indicate where the DPH system should input data
The black boxes indicate Milestones and will automatically populate and flow to summary sheets
The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
populate and flow to summary sheets

Enhance Performance Improvement and Reporting Capacity

DY Total Computable Incentive Amount: *

Incentive Funding Already Received in DY: *

Process Milestone: _____
                                          (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

    Achievement   N/A

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: *

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

    Achievement Value

Process Milestone: _____
                                          (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

    Achievement   N/A

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: *

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

    Achievement Value

DSRIP Semi-Annual Reporting Form

Category 1: Enhance Performance Improvement and Reporting Capacity

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   `* [____]`

Denominator (if absolute number, enter "1")   `* [____]`

Achievement   `[ N/A ]`

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: `* [____]`

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   `* [____]`

Achievement Value   `[____]`

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   `* [____]`

Denominator (if absolute number, enter "1")   `* [____]`

Achievement   `[ N/A ]`

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: `* [____]`

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   `* [____]`

Achievement Value   `[____]`

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   `* [____]`

Denominator (if absolute number, enter "1")   `* [____]`

Achievement   `[ N/A ]`

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: `* [____]`

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   `* [____]`

Achievement Value   `[____]`

DSRIP Semi-Annual Reporting Form

Category 1: Enhance Performance Improvement and Reporting Capacity

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   N/A

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: *

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

   Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   N/A

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: *

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

   Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   N/A

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: *

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

   Achievement Value

DSRIP Semi-Annual Reporting Form

Category 1: Enhance Performance Improvement and Reporting Capacity

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

    Achievement   [N/A]

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: *

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

    Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

    Achievement   [N/A]

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: *

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

    Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * [   ]

Category 2: Expand Medical Homes

Below is the data reported for the DPH system.
Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).
* [ ] The yellow boxes indicate where the DPH system should input data
[ ] The black boxes indicate Milestones and will automatically populate and flow to summary sheets
[ ] The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
populate and flow to summary sheets

Expand Medical Homes

DY Total Computable Incentive Amount: * [   ]

Incentive Funding Already Received in DY: * [   ]

Process Milestone: _____
                                           (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

   Achievement Value   [   ]

Process Milestone: _____
                                           (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

   Achievement Value   [   ]

Category 2: Expand Medical Homes

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) `*` [   ]

Denominator (if absolute number, enter "1") `*` [   ]

Achievement [N/A]

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: `*` [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone `*` [   ]

Achievement Value [   ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) `*` [   ]

Denominator (if absolute number, enter "1") `*` [   ]

Achievement [N/A]

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: `*` [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone `*` [   ]

Achievement Value [   ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) `*` [   ]

Denominator (if absolute number, enter "1") `*` [   ]

Achievement [N/A]

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: `*` [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone `*` [   ]

Achievement Value [   ]

Category 2: Expand Medical Homes

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)　*

Denominator (if absolute number, enter "1")　*

　Achievement　　　　　　N/A

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:　*

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

　Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)　*

Denominator (if absolute number, enter "1")　*

　Achievement　　　　　　N/A

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:　*

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

　Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)　*

Denominator (if absolute number, enter "1")　*

　Achievement　　　　　　N/A

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:　*

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

　Achievement Value

Category 2: Expand Medical Homes

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

DSRIP Semi-Annual Reporting Form

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

DPH SYSTEM: Santa Clara Valley Medical Center

REPORTING YEAR: DY 7

DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * Yes

Category 2: Expand Chronic Care Management Models

Below is the data reported for the DPH system.

Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',

please type in all of your DY milestones for the project below and report data in the indicated boxes (*).

* ☐ The yellow boxes indicate where the DPH system should input data

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☐ The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically

populate and flow to summary sheets

Expand Chronic Care Management Models	
DY Total Computable Incentive Amount:	* $ 14,500,000.00
Incentive Funding Already Received in DY:	* $ 12,687,500.00
Process Milestone: 1. Formalize multi-disciplinary teams.	
(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

Metric: Hire at least 2 additional care managers to assist with chronic disease management; determine optimal care manager to diabetic patient ratio.

In order to have at least 2 additional Care Managers (CMs) start seeing patients in September 2011, we hired three full-time Ambulatory Pharmacist Care Managers in May 2011. The CM's participated in a 3-month training and orientation (June-August, 2011) coordinated by the pharmacy department and the Diabetes Center. In September 2011, the CMs started seeing patients with diabetes in the outpatient clinic under MD supervision, using evidence-based protocols to manage diabetes, hypertension and dyslipidemia. In November 2011, these CMs were managing patients independently using these protocols.

Using our electronic registry to identify patients with diabetes and primary care panel data, we calculate on a quarterly basis the current CM: diabetic patient (DM) ratio and assess the quality outcome metrics for each CM and primary care clinic. As of 6/30/12, the CM: DM pt ratio in our Medical Homes ranged from 1:575 to 1:1174. Our data suggest that the "optimal" ratio is close to 500:1. In sites where we have a very high DM pt: CM ratio, we are limited by physical space considerations as well as the structure of the medical home where we try to link one CM to the group of PCPs in the Medical Home. Over the past year, our approach in these "high DM pt ratio" sites is to try to make the CM more efficient by hiring more MA support to off-load the CM from some of the outreach and registry tasks and allow the CM to focus on complicated management decisions. As we continue to hire and train additional CMs and deploy them in the primary care clinics, our goal is to approach this more optimal range. Factors that affect this range include level of clerical and MA support, degree of team development in the Medical Home, and level of expertise with the electronic registry.

With the additional CM hiring, we have been able to deploy an additional CM at Milpitas Medical Home and plan to deploy an additional CM at Tully clinic in August 2012.

Additionally, since 12/11, we have hired an additional four MAs who are assigned to support the CMs in their panel

DSRIP Semi-Annual Reporting Form

Category 2: Expand Chronic Care Management Models

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

* Yes

Achievement Value

1.00

Process Milestone: 2. Train staff in components of the care model including quality measurement, primary care redesign, and financing chronic care model.

(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

SCVMC has hosted a Chronic Care Symposium annually, beginning in 2009, with the goal of educating interested SCVMC staff as well as stakeholders in the community on chronic care issues, with a perspective on local, state and national issues. On May 18, 2011, the focus of the symposium was "Health Care Reform and Chronic Care". Topics covered included quality improvement (The Kaiser Experience), primary care re-design (The Medical Home at SCVMC) and financing. The symposium was attended by a total of 122 people, 77 of whom were SCVMC staff.

We have ongoing training on different aspects of the Chronic Care Model, primarily in the Diabetes Center staff meetings, which are attended by pharmacists, nurses, social workers, MAs, clerks, and MDs.
 Examples:
a. 12/13/11: The Chronic Care Model and Population Management Tools

Objectives:
• 1. Review the Chronic Care Model (CCM)
• 2. Describe examples of the CCM in action at VMC, including IS initiatives
• 3. Introduce the PHASE initiative
• 4. Detail changes in reimbursement that depend on implementation of the CCM

b. 4/10/12: Filemaker (electronic registry) training

Objectives:

1. Understand what a registry is and how it supports population management.
2. Understand the SCVMC registry, the sources of data, and the specific tools for Diabetic Care Managers and Medical Assistants.
3. Be able to use the SCVMC registry to perform the following tasks:
     a. Access the diabetes template, review patient history, and enter a new patient
     b. Enter outside labs, eye exams, and medications
     c. Enter a patient expiration
     d. Utilize quick reports to identify groups of patients in need of screening, including printing the report, and performing basic functions in Excel to manipulate the data.
4. Know how to get additional support when needed.

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

* Yes

Achievement Value

1.00

Category 2: Expand Chronic Care Management Models

Process Milestone:	3. Train relevant staff in the chronic care model in at least 25% (2 out of 7) of medical home teams.

(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]

Metric: Documentation of institution-wide training symposium to educate staff on chronic care issues and care model; report number of staff trained.

Metric: Documentation of training program and list of staff members trained, or similar documentation.

On November 18, 2011, we gave a presentation to the staff at the Gilroy Medical Home and the Milpitas Medical Home entitled "The Chronic Care Model in Action at VMC".   The audience included the entire staff of each Medical Home (MD, RN, MA, pharmacists, and clerks).   The goals of the talk included reviewing the main tenets of the Chronic Care Model and examples of how we incorporate the model at SCVMC. We emphasized its importance to the medical home, healthcare reform, changes in reimbursement and most importantly to improving the health of patients. Special attention was paid to how the model fits with the care management model and our new registry/population management tool in order to provide context to the staff with regards to the changes in our system.

Subsequent trainings in 12/11 and 4/12 focused on electronic registry functionality and included specific trainings on some of the new tools that have been developed in our registry (quick reports updated weekly listing patients who are overdue for key lab such as A1c, LDL-C or retinal screen, diabetes diagnosis over-ride tools, trainings on how to enter outside labs and tests, basic spreadsheet use).

Future trainings will focus on HealthLink (New electronic health records system) registry tool, integration of diabetes care management with primary care and specialty care, promotion of team-building for efficient population outreach.

We engage in several activities to assess the effectiveness of the training. The staff completes "speaker evaluations" after their training sessions which include surveys asking participants what they have learned and how they will apply it to their clinic. These evaluations and surveys are reviewed by the speakers and supervisors. We also evaluate the effectiveness of our trainings by looking at longitudinal quality data by medical home (e.g. IDL and A1c testing rates). Teams that are not showing significant improvement in these metrics are given this feedback.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   *[Yes]

Achievement Value   [1.00]

Process Milestone:	4. Utilize elements of chronic care model in at least 25% (2 out of 7) of medical home teams.

(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]

Category 2: Expand Chronic Care Management Models

Metric: Demonstrate Chronic Care Model implementation (decision support tools, delivery system design, clinical information systems) for at least 25% (2 out of 7) of Medical Home teams using optimal care manager staffing ratio.

The Chronic Care Model is at the core of the care that is delivered for patients in the Medical Home. Using diabetes management as a model, listed below are some examples from the 4 main tenets of the CCM used at two of our Medical Home teams, Milpitas and Gilroy.

1. Self-management support: Empower and prepare patients to manage their health and health care
   a. Group & individual instruction on diabetes basics, nutrition, self-monitoring, complications, exercise, and glucose interpretation delivered by diabetes care managers.
      1. "Taking Control Of Your Diabetes" workshop "Get Ready! Get Fit! Go" workshop
      2. Patient self-management educational materials. Education workshops offered at focusing on self-management skills, and self-management education
   b. Chronic Disease Self-Management (AKA Healthier Living) course – 6 week peer-led group focused on self-management strategies. 12-16 workshops held per year at various clinic sites, in English and Spanish available for free and available to all SCVMC patients.

2. Delivery system design: Assure the delivery of effective, efficient clinical care and self-management support

   a. Diabetes Care Managers (RN coordinators or clinical pharmacists) hired, trained and deployed in the Medical Home to support a team of PCPs to manage specific populations of patients (e.g. diabetes).

   b. PCPs give authorization to the Care Manager (CM) to manage all patients in a population using all approved protocols.

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

Process Milestone: 5. Implement program to identify and manage targeted patients needing further clinical intervention for at least 1 outcome.

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*
Denominator (if absolute number, enter "1")	*
Achievement	N/A

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: *

Metric: Documentation of program implementation

The American Diabetes Association recommends screening for diabetic retinopathy on an annual basis.

Based on data from our electronic registry as of September 30, 2011, retinal screening rates for patients with diabetes from two of our Medical Homes, Sunnyvale (SV) and Milpitas (MIL), were sub-optimal.
In October 2011, we used our electronic registry to identify all patients in these two Medical Homes who had not had a retinal exam within two years. Insurance authorization requests were submitted by clerks for this procedure.   Interactive Voice Response (IVR) technology was used to call all of these patients in their native language informing them to make an appointment for a retinal camera screen (fundus photography). In addition, lists of patients who were due for a retinal exam were distributed to the staff at the Medical Homes and they were encouraged to perform outreach via telephone or letter to increase the yield.

Category 2: Expand Chronic Care Management Models

Diabetic Retinal Screening Rates Pre and Post-IVR Intervention for Sunnyvale (SV) and Milpitas Clinics

		SV Clinic	MIL Clinic
Baseline (911)	Total DM Pts	761	1040
# pts screened (%)	1-Year	332 (44%)	450 (43%)
# pts screened (%)	2-Year	480(63%)	657 (63%)
Post-IVR (3/12)	Total DM pts	797	1090
#pts screened (%)	1-Year	346 (43%)	445(41%)
# pts screened (%)	2- year	558 (70%)	683(63%)

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * Yes

Achievement Value   1.00

Category 2: Expand Chronic Care Management Models

Improvement Milestone:	6. Apply the chronic care model to the management of glycemic control and dyslipidemia in diabetes.

(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]

Metric: Documentation of program.

The Chronic Care Model (CCM) is at the core of the care that is delivered for patients with diabetes at SCVMC. Listed below are some examples from the 4 main tenets of the CCM applied to the management of glycemic control and dyslipidemia in diabetes.

1. Self-management support: Empower and prepare patients to manage their health and health care
   a. Group & individual instruction on diabetes basics, nutrition, self-monitoring, complications, exercise, and glucose interpretation delivered by diabetes care managers.
      1. "Taking Control Of Your Diabetes" workshop
      2. Patient self-management educational materials
      3. Education workshops offered at focusing on self-management skills
   b. Chronic Disease Self-Management (AKA Healthier Living) course – 6 week peer-led group focused on self-management strategies. 12-16 workshops held per year at various clinic sites, in English and Spanish available for free to all VMC patients. This course is offered to all patients with diabetes.

2. Delivery system design: Assure the delivery of effective, efficient clinical care and self-management support
   a. Diabetes Care Managers (RN coordinators or clinical pharmacists) hired, trained and deployed in the Medical Home to support a team of PCPs to manage specific populations of patients (e.g. diabetes).
   b. PCPs give authorization to the Care Manager (CM) to manage all diabetes patients in a population using all approved protocols, including glycemic and lipid management
   c. MAs support the CMs work on glycemic control by obtaining BG results, facilitating updating of labs, and assist with registry queries.
   d. CM clinic schedules revised to allow more telephone follow-up appointments to allow glycemic medication adjustments to be made over the phone based on blood sugars, improve efficiency and convenience for patients

Category 2: Expand Chronic Care Management Models

and convenience for patients

3. Decision support tools: Promote clinical care that is consistent with scientific evidence and patient preferences

  a. CMs in Medical Homes function under physician-written, hospital-approved, evidence-based and target-driving management protocols based on national guidelines for Glycemic Management and Lipid Management. Multiple options available for most protocols such that management can accommodate patient preference. The protocols are revised every 2 years by a team including input from endocrinology, pharmacy and care managers based on new data and/or revised guidelines from relevant professional societies.

  b. CMs incorporate these management protocols in their daily work to support the PCP in optimizing glycemic and lipid management in diabetes.

4. Clinical Information Systems: Organize patient and population data to facilitate efficient and effective care

  a. We first established an electronic patient registry (Filemaker Pro, FMP) in 2001 to track certain populations of patients (e.g. diabetes, anti-coagulation). As of 6/30,2012, there are 19,798 diabetes patients in the registry.
  b. Diabetes care managers actively use the registry to track population outcomes, identify high-risk sub-populations, send out reminders and individualize plans related to glycemic and lipid management.
  c. Below please find figures showing significant improvements in the overall rate of annual   LDL-cholesterol testing, A1Cctesting and overall LDL and A1c control that we attribute in large part to expansion and implementation of the Chronic Care Model in the Patient-Centered Medical Homes.
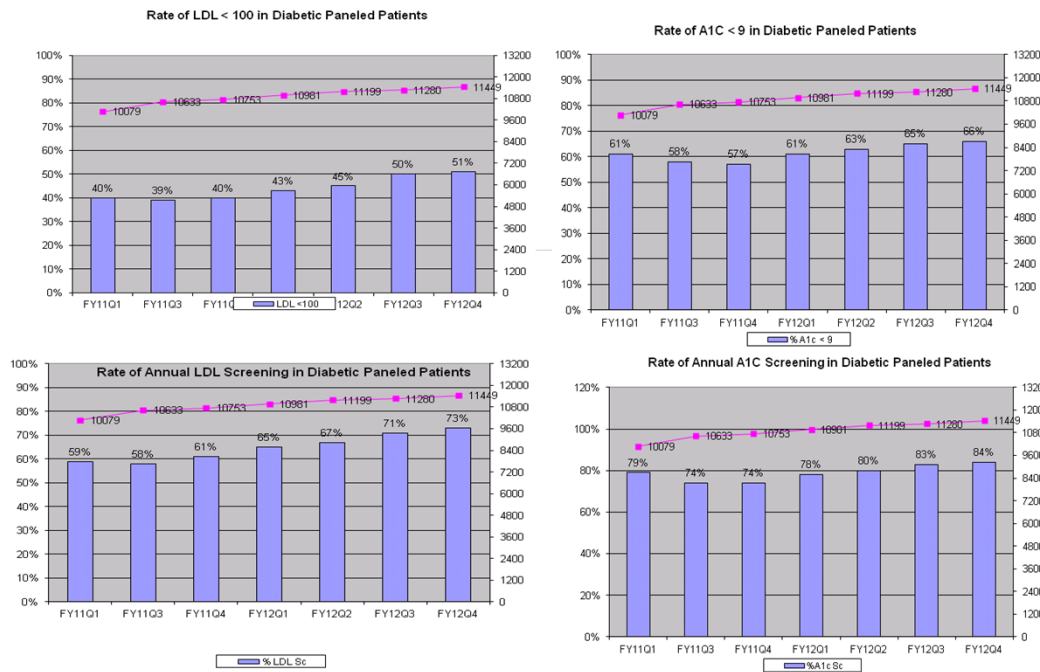
DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone

Category 2: Expand Chronic Care Management Models

Achievement Value   1.00

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * [   ]

Category 2: Redesign Primary Care

Below is the data reported for the DPH system.
Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).
* ☐ The yellow boxes indicate where the DPH system should input data
☐ The black boxes indicate Milestones and will automatically populate and flow to summary sheets
☐ The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
populate and flow to summary sheets

Redesign Primary Care	

DY Total Computable Incentive Amount: * [   ]

Incentive Funding Already Received in DY: * [   ]

Process Milestone: _____
                                              (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

   Achievement Value   [   ]

Process Milestone: _____
                                              (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

   Achievement Value   [   ]

DSRIP Semi-Annual Reporting Form

Category 2: Redesign Primary Care

Process Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   `N/A`

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: *

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

   Achievement Value

Process Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   `N/A`

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: *

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

   Achievement Value

Process Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   `N/A`

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: *

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

   Achievement Value

DSRIP Semi-Annual Reporting Form

Category 2: Redesign Primary Care

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

Achievement N/A

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: *

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

Achievement Value

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

Achievement N/A

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: *

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

Achievement Value

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

Achievement N/A

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: *

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

Achievement Value

DSRIP Semi-Annual Reporting Form

Category 2: Redesign Primary Care

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * Yes

Category 2: Redesign to Improve Patient Experience

Below is the data reported for the DPH system.
 Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).
* ☐ The yellow boxes indicate where the DPH system should input data
 ☐ The black boxes indicate Milestones and will automatically populate and flow to summary sheets
 ☐ The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
   populate and flow to summary sheets

Redesign to Improve Patient Experience

DY Total Computable Incentive Amount: * $ 5,000,000.00

Incentive Funding Already Received in DY: * $ 3,437,500.00

Process Milestone: 1. Include key stake holders in assessment of patient experience tool.
                                                     (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

Goal

In DY 6, Santa Clara Valley Medical Center (SCVMC) completed a literature review on improving the patient/family experience. The results clearly suggest that consistently great patient experience is not a matter of attitude, awareness or positive intent. It is a matter of design where both organizational and tactical strategies are represented. One key strategy is the implementation of a patient experience tool that helps define, measure, analyze, improve and control elements of improvement projects.

At the beginning of DY 7, SCVMC did not have a clearly defined process for identifying and responding to opportunities to improve the patient experience. Our goal in DY 7 was to include key stake holders in the assessment of a patient experience tool for enterprise-wide adoption.

Overview

In October 2011, SCVMC applied to and was accepted into the Patient Experience Transformation (PExT) Initiative Action Collaborative. The PExT Initiative is a program of the California Health Care Safety Net Institute (SNI) in conjunction with ExperiaHealth. The PExT Initiative is a demonstration project in which participating organizations implement a proven tool to rapidly transform patient experience.

Over the course of nine months, SCVMC completed an end-to-end analysis of the patient and employee experience in the Valley Health Center Moorpark Medicine Clinics to identify experience gaps, engage a multidisciplinary team to design the ideal experience, and deploy experience improvements. At the conclusion of the PExT Initiative in June 2012, participating health systems presented at a conference hosted by SNI. There, SCVMC received top recognition for implementing the patient experience tool to create innovative and sustainable change. SCVMC subsequently presented their project experience at the National Association of Public Hospitals and Health Systems (NAPH) Conference in San Francisco in June 2012.

Process

SNI provided ongoing and multiple forms of support throughout the PExT Initiative via conference gatherings, webinars, and one-on-one telephone coaching sessions. Support was provided in the areas of assessment, project management, communication, and data collection.

The PExT team consisted of both providers and non-providers staff. The team had strong support from the Chief Executive Officer. She was engaged in the initial selection of the study site, project design, received regular project updates, and gave input to the team.

SCVMC has a limited history of patient participation in improvement projects. The organization recognizes the value of a direct patient perspective, but was unable to conduct the recommended interviews and patient focus groups within the PExT project's aggressive timeframe. Alternately, staff conducted telephone surveys of a representative number of

Category 2: Redesign to Improve Patient Experience

patients seen

in the Valley Health Center Moorpark Medical Clinics. Also, two patients with extensive history at the Moorpark Clinic were invited to participate in the design sessions and their video interview was included in the final project presentation at SNI. SCVMC is reviewing opportunities to regularly involve patients in future efforts.

The PExT project manager provided regular updates at clinic staff meetings and at the Primary Care Division's Patient Experience Workshop. The provider-led Patient Experience Workshop was supportive of the PExT project and discussed opportunities to apply best practices to other clinic sites.
In addition, the PExT project manager reported regularly to the Customer Experience Committee which helps correlate patient improvement projects at SCVMC. At the end of the nine month pilot project, the Customer Experience Committee made recommendation to the Chief Executive Officer and the Santa Clara County Board of Supervisors that the patient experience tool be officially adopted as a guide for all patient experience improvement projects. Initial plans have been made to train additional staff in using the patient experience tool so performance improvement projects will be standardized across the organization and more readily resourced with project managers. To that end, SCVMC also plans to participate in the upcoming train-the-trainer program offered by SNI.

Data
The following data sources are pertinent to the PExT Initiative project at SCVMC:
□ Professional Research Consultants (PRC)
□ Internal patient survey
□ Internal staff survey
□ Staff Pulse survey

SCVMC has trended patient satisfaction data captured through telephone exit surveys conducted by Professional Research Consultants (PRC). The surveys track patient satisfaction for multiple points of care. A key metric used by SCVMC is patients' "excellent" responses regarding staff courtesy and friendliness.
The Valley Health Center Moorpark Medical Clinics' percentile ranking for staff courtesy and friendliness changed dramatically during the course of the PExT Initiative. Third quarter data for 2011 corresponds with the start of the PExT program. At that time, the Moorpark clinics ranked in the eighth percentile. Clinic ranking after the first quarter of 2012 was over the seventeenth percentile. Staff's euphoria was dashed when ranking for the second quarter of 2012 was just over the second percentile. It is uncertain whether or not there is a strong correlation between implementation of the PExT project and patients' perception of staff courtesy and friendliness.

PRC Percentile Ranking for "Excellent" responses to "Staff Courtesy and Friendliness"
Quarter 3, 2011: 8.0 percentile
Quarter 4, 2011: 19.7 percentile
Quarter 1, 2012: 70.5 percentile
Quarter 2, 2012: 2.5 percentile

To get more detailed information regarding patient clinic experience, the project team created a simple eight question survey.. Patients were randomly selected from a list of clinic visits completed during a five day period. The surveys were conducted in the patients' preference of English, Spanish, or Vietnamese. Survey findings included:
    □ 51% highly rated the courtesy and friendliness of clinic staff
    □ 48% poorly rated the experience of calling to make an appointment
    □ 52% poorly rated the experience of calling for medical advice
    □ 47% of patients said the process of leaving a message for doctors was only "good" with another 34% rating the process poorly

Patient comments reinforced a focus on telephone access issues and also highlighted patient frustration about pharmacy processes.

Staff feedback was collected through two surveys. In the Pulse survey, 20% of staff responses pointed to access issues and long waiting time for patients. Aggregated responses suggested that most messages are generated by patients coming into the clinic or by faxes received from the Valley Connection call center. Clinic staff prefers fax or telephone messages over patient walk-ins. Problems associated with messages received include having incorrect or incomplete data. Barriers to responding to patient messages in a timely manner include incorrect/incomplete patient information,

 staffing resources, and language barrier.

Based on a review of data, the project team identified quick solutions and long-term goals for improving patient satisfaction in the area of telephone call handling and messaging to providers.

Category 2: Redesign to Improve Patient Experience

Challenges

One of the biggest challenges facing the PExT team was finding time to meet and work on the patient experience project. The staff prioritizes direct patient care. So, project team meetings were often scheduled at the lunch hour to accommodate heavily impacted clinic schedules. However, that failed to accommodate all team members. To compensate, the project manager made heavy use of email communications.

Defining the project scope was also a challenge. The PExT team identified several opportunities to improve the patient experience which required collaboration with other departments. Some project opportunities targeted enterprise-wide processes. As a result, some of the PExT team goals were not realistically achievable in the context of the project's time frame, resources, and circle of influence.

Several team members participated in the project to improve patient experience. It is recommended the patient experience tool be enhanced to provide more support in defining a workable project scope.

Finally, most effective implementation of the patient experience tool would be in the context of a strong, visible, organizational structure that correlates the design, development, implementation and evaluation of improvement projects across the institution.

Outcomes

Work on this milestone resulted in targeted improvements in processes supportive of the patient experience at the Valley Health Center Moorpark Medical Clinics. It also resulted in the development of project management staff familiar with the patient experience tool. The patient experience tool was customized to meet organizational processes. This milestone

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

Process Milestone: 2. Write and obtain approval for SCVMC patient/family experience strategic plan.

(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

Goal

In DY 6, SCVMC completed a literature review on improving the patient/family experience. From that, we learned that patient experience is a composite of all interactions with a healthcare delivery system – direct and indirect, clinical and non-clinical. As a result, strategic planning and organization are essential. Planning and organization arguably trump attitude, awareness, or positive intent in creating consistently great patient experiences. Careful planning helps align goals as well as systems across the organization. It also establishes clear expectations, enhances staff accountability, and gives direction for hiring and skill development. Our goal in DY 7 was to write and obtain approval for a patient/family experience strategic plan.

Process

On 11/15/2011, the first strategic plan draft was reviewed by members of the Customer Experience Committee. This committee is a cross-functional team whose purpose is to correlate patient experience initiatives at SCVMC. The committee includes several top leaders and administrators.

Feedback from the Customer Experience Committee suggested a re-write of the document. Elements to retain in the strategic plan included:
☐ Organizational leadership and communication
☐ Patient satisfaction metrics
☐ Employee engagement/recognition

On 2/16/12, we had a telephone coaching session with members of SNI and ExperiaHealth regarding the creation of a patient/family strategic plan. The plan was revised and presented to the Customer Experience Committee on 4/17/2012. The strategic plan was revised to include work from the expanded Customer Experience Committee groups, and at its 5/15/2012 meeting, the Customer Experience Committee recommended organizational adoption of the patient/family

Category 2: Redesign to Improve Patient Experience

~~6/18/2012 meeting, the Customer Experience Committee recommended organizational adoption of the patient/family~~ experience plan.

On 6/6/2012, the Santa Clara County Board of Supervisors accepted Santa Clara Valley Medical Center's patient/family strategic plan as written.

Future goals include ongoing updates to the action items and timeframes to accomplish the plan goals.

Category 2: Redesign to Improve Patient Experience

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * Yes

Achievement Value   1.00

Process Milestone: 3. Sub-committees implement plans to improve: First contact and inpatient noise.

(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

First Contact

Goal

Staff courtesy and friendliness affect patients' overall perception of quality of care. In DY6, Santa Clara Valley Medical Center successfully launched the "Every Contact Counts" campaign to train staff on "first contact" expectations. The campaign focused on enhancing verbal and non-verbal communication, listening skills, and patient handoffs. Our goal in DY7 was to identify and implement next steps towards making patients feel cared about while being cared for.

Process

On a monthly basis, the Customer Experience Committee reviews patient satisfaction data to identify opportunities for improving the patient/family experience. A sub-group of the Customer Experience Committee directs ongoing efforts of the "Every Contact Counts" campaign. To reinforce "first contact" expectations introduced in DY6, units and departments were encouraged to make videos demonstrating best customer service practices. Videos were judged on how well they represented "first contact" criteria, including greeting patients by name, introducing self and role, verbalizing goals for the interaction, and asking what else the patient needs.

The top ten videos were posted on SCVMC's intranet for staff viewing. The videos were also shown in live audience settings to accommodate staff with limited computer access. Staff was further engaged by being encouraged to vote for the "People's Choice" video award. The videos were a good review and reinforcement of best customer service practices.

Staff engagement and patient experience data was used to identify next steps. Staff recognition was singled out as an area of focus. Also identified was increasing top-down leadership and accountability for creating positive patient experiences beyond the first contact.

Many efforts were made to expand and increase recognition of individual staff and teams.
  ☐ The Chief Nursing Officer regularly recognized units and clinics with improved patient experience scores.

  ☐ Compliment certificates were redesigned to reflect the "Every Contact Counts" branding, and 1425 official compliments to staff were processed.

  ☐ A "Wow" card was designed, evaluated by key players, and approved for implementation. The "Wow" card will be a vehicle for patients to give specific and immediate feedback to staff on positive performance.

  ☐ An internal email account was created specifically for employee recognition. It is used for two-way communication between staff and the Customer Experience Committee about stellar efforts towards patient experience. An "Every Contact Counts" recognition template was designed for staff acknowledgements coming from this dedicated email account.

  ☐ An "Our Stories" publication was created. It showcases the work of teams and programs whose work specifically benefits patients. "Our Stories" is distributed electronically to staff. It is also printed for hard copy distribution to patients in acute and ambulatory waiting areas.

Increasing top-down leadership and accountability for patient experience beyond the first contact was also a priority. Executive leadership was involved in several discussions for this phase of "Every Contact Counts." The outcome of those discussions was a commitment on the part of executive leaders to increase their direct patient contact, consistently model "first contact" behaviors, and communicate with staff to identify barriers to service delivery.

The CEO drafted an interview outline for executive leaders to use in conducting regular one-on-one visits with patients. The guide helps capture key information about patients' real-time experience, including unaddressed needs, the environment of care, and stellar staff performance. It is anticipated that regular, executive-level interviews with patients

Category 2: Redesign to Improve Patient Experience

environment of care, and stellar staff performance. It is anticipated that regular, executive-level interviews with patients will emphasize

organizational commitment to patient satisfaction, model "first contact" behaviors, and help grow a culture of leadership and accountability for the patient experience.

Data

The following is a summary of data regularly reviewed in our ongoing work to improve patient experience in the area of "first contact."

Patient Satisfaction Results:
  Hospital-based care: There was a significant improvement in metrics for both "Staff Courtesy and Friendliness" and "Likelihood to Recommend" during the period of December 2011 to February 2012. National ranking for staff courtesy peaked at the seventy-ninth percentile during this time. However, at the end of DY7, satisfaction scores in both areas returned to their previous levels.

  Ambulatory care: Scores for "Staff Courtesy and Friendliness" and "Likelihood to Recommend" remained relatively unchanged throughout DY7.

Employee Engagement Survey: A second annual employee engagement survey was conducted to measure staff level of commitment and engagement to SCVMC and it's mission.
Staff strongly agreed with the following:
  ☐ Have a sense of accomplishment about daily work
  ☐ Strongly feel their role is important to patients
  ☐ Feel co-workers are respectful and willing to help
  ☐ Proud to work at SCVMC
Opportunities for improvement:
  ☐ Having adequate resources to do their job
  ☐ Suggestions for improving performance
  ☐ Departments work as one team to support organizational mission
  ☐ Praise and recognition
  ☐ Communication to and from staff about important issues

Challenges

Patient experience initiatives faced competing priorities, including significant budget cuts, implementation of an electronic medical record, and several accreditation surveys during DY7. In addition, there were changes in key leadership positions. These challenges made it difficult to maintain a concerted focus on "first contact" initiatives.

Another challenge to work in this area is staff's lack of confidence in existing patient satisfaction data. The current satisfaction survey for outpatient care is comprehensive. It includes questions about clinic visits, appointment scheduling, laboratory, and radiology services. Staff perceives that clinic satisfaction scores may be negatively affected by the broad nature of the survey tool. In response, many clinics created their own patient satisfaction surveys. The validity and

Category 2: Redesign to Improve Patient Experience

nature of the survey tool. In response, many clinics created their own patient satisfaction surveys. The validity and reliability of these surveys was not assessed, nor do the surveys have benchmark comparisons. SCVMC Medical Center subsequently re-evaluated its patient satisfaction tool and decided to implement the CG-CAHPS survey in all ambulatory settings.

In communicating patient satisfaction, the organization references various metrics, including "Staff Courtesy and Friendliness," "Likelihood to Recommend," and "Overall Quality of Care." Though the data are often parallel, this may result in some data overload and lack of focus. Currently, a dashboard is being created to clearly and consistently communicate quality and patient experience data across the organization.

Finally, identifying the difference between training needs and culture change was another challenge addressed in DY7. In planning next steps for the "Every Contact Counts" campaign, multiple training outlines were created and discarded in trying to identify pertinent learning objectives. It was finally determined that training is less of a need than is affecting a culture of staff engagement and accountability. Current work proceeds in that area.

Outcomes

In DY7, work to improve "first contact" with patients resulted in several positive outcomes. There was widespread support for the ongoing "Every Contact Counts" campaign where staff engaged in the creation and viewing of videos demonstrating best customer service practices.

Also, in direct response to patient satisfaction and employee engagement data, we created improved tools and process for staff recognition; outlined plans to improve leadership and accountability for the overall patient experience; re-evaluated patient experience tools and initiated the development of a dashboard to communicate quality and patient experience data.

Inpatient Noise

Goal

Excessive noise is often a chief complain of hospital patients, and according to some studies, may even slow healing

time. Some studies also suggest a correlation between noise and stress among healthcare workers. The goal of the Quiet Team is to promote optimum rest and healing for patients in the acute care setting and to also provide a healthy work environment for staff.

Process

The Quiet Team meets monthly to review patient satisfaction data related to noise and to manage ongoing efforts to create a quiet, restful environment. Regular reports are made to the Customer Experience Committee which correlates and supports the work of patient experience initiatives at Santa Clara Valley Medical Center.

Quiet Team interventions have become increasingly data-centric. HCAHPS scores on noise are reviewed regularly. However, when posted, HCAHPS data is between nine and eighteen months old. More timely data is needed in order to accurately assess the effectiveness of noise reduction interventions. To that end, the Quiet Team created an internal survey to better identify the elements affecting patient perceptions about quiet in the inpatient setting. On an on-going basis, staff and trained volunteers conduct surveys in face-to-face interviews with patients. Efforts are made to conduct the surveys in the top three languages reflective of our patient population, namely: English, Spanish, and Vietnamese. Patients are asked about the time of day when noise is most disruptive. They are also asked to rate common noise sources.

The Quiet Team also created graphic-rich "Quiet Zone" posters and tent cards for distribution across all inpatient units.

Category 2: Redesign to Improve Patient Experience

Current objectives include:
- Unit by unit campaign to raise awareness of the importance of quiet
- Distribution of promotional materials, including: posters and lapel buttons
- Ongoing assessment of janitor cleaning schedules and cart noise
- Ongoing efforts to reduce number and volume of overhead announcements
- Nurses to offer earplugs to all patients
- Identify Quiet Team Champions for relevant areas
- Where appropriate, staff to ask patients if they want their doors closed to sleep
- Recommend that leaders model desired behavior by observing designated Quiet Zones using hushed voices in acute care areas
- Medication carts used for bar code administration to be labeled as Quiet Zones
- Evaluate with Information Services the feasibility of a screen save on all monitors to read: "Quiet Zone"

Data

The most current HCAHPS results reflect the period from July 1, 2010 to June 30, 2011 where thirty percent of patients indicated the area surrounding their room was quiet at night. There was no change in this score from the previous reporting period.

Between April 27, 2012 and July 13, 2012, one hundred eight patient responses were collected in an internal survey. Patients generally reported it is "sometimes" quiet around their rooms with noise levels greatest in the morning and evening hours. The most frequently identified noise sources were overhead announcements and traffic in the hallway. Staff conversations also ranked highly. Over ninety percent of patients reported staff did not offer them ear plugs.

Challenges

At SCVMC, many of the acute care rooms are semi-private which makes it difficult to control the noise generated by roommates and roommate visitors.
Current construction of a new hospital wing with all private rooms will remove many of the challenges related to physical environment. The new building completion is anticipated in 2014.

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

Process Milestone:	4. Implement plans for regular organization-wide communication of patient experience data and efforts to improve patient/family experience.
	(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

Goal

Our goal for DY7 is to demonstrate regular communication with all staff about patient experience data and efforts to improve the patient/family experience at SCVMC.

Process

SCVMC has several sources of data regarding patient experience, including scores from patient satisfaction surveys conducted by Professional Research Consultants (PRC); HCAHPS data; and patient concerns. Executive leadership regularly monitors and communicates performance in this area. A preferred metric is, "Would you recommend Santa Clara Valley Medical Center to a friend or relative?"

In DY7, the CEO regularly communicated patient experience scores and goals via enterprise-wide email and monthly reports to division managers. Starting May 30, 2012, patient satisfaction rankings for hospital units and clinics were posted weekly on the organization's intranet. Updates were also provided to the organization's governing Board of Supervisors. In addition, the Chair of the Customer Experience Committee presented detailed patient experience data, on request, to specific clinics and division manager meetings. Discussions are also underway to develop a plan to measure the effectiveness of these activities.

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

Process Milestone:	
	(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*

Category 2: Redesign to Improve Patient Experience

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

   Achievement Value   [   ]

Category 2: Redesign to Improve Patient Experience

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

   Achievement Value   [   ]

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

   Achievement Value   [   ]

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

   Achievement Value   [   ]

Category 2: Redesign to Improve Patient Experience

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * | Yes |

Category 2: Redesign for Cost Containment

Below is the data reported for the DPH system.
 * *Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',*
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).
 * ☐ The yellow boxes indicate where the DPH system should input data
    ■ The black boxes indicate Milestones and will automatically populate and flow to summary sheets
    ☐ The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
       populate and flow to summary sheets

Redesign for Cost Containment

DY Total Computable Incentive Amount: * $ 3,511,000.00

Incentive Funding Already Received in DY: * $ 1,462,916.67

Process Milestone: 1. Continued implementation of a cost accounting system to measure intervention impacts.
_____
                                                      (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 |

The contract for implementation of the cost accounting system was signed on December 22, 2011. The six months leading up to the signing included requirements redesign, RFP development, selection of a vendor, development of deliverables and compensation plan, a detailed statement of work, a work plan time line, and detailed tasks/methodology to achieve each milestone.

The final solution included a combination of existing technology, new technology, and outsourced services. A pre-kick off meeting was held in December 2011 to determine the next steps so that the project could kick off after the holidays.

The project started in January 2012. Tasks started and completed through June 30, 2012 included the Technical and Application Setup, Data Inputs, and Data Mappings. The Technical and Application Setup included the creation of the Santa Clara Valley Medical Center (SCVMC) instance on the Organizational Intelligence (OI) server. The setup was validated and logins were created for the OI consultants. The next task, Data Inputs, included loading of the general ledger accounts and cost centers, loading of actual revenue volumes by month, developing budget methodology for volumes and loading the budget, loading of general ledger actual and budgets, loading job and pay codes, and loading payroll dollars into the OI system. The next task, Data Mappings, included categorizing cost centers as either direct, indirect, or dead-ended; defining cost categories for each cost type (fixed, variable, equipment, facilities, other); mapping exceptions; defining variable and fixed percents for all departments; and assigning job codes and payroll general ledger accounts to pay categories. In addition, some of the Relative Value Unit (RVU) training tasks were completed by June 30, 2012. They included customizing the training materials for SCVMC, providing cost accounting concepts training sessions to the SCVMC Finance team, and providing Cost Accounting Concepts training sessions for the RVU participants (cost center managers and other key staff). Half of the scheduled Cost Accounting Concepts training sessions were completed by June 30, 2012. Training for the Finance team will continue, but training and participation for the two staff assigned for knowledge transfer will be more intensive. RVU planning and approach activities were also completed in June.

Tasks started and not completed as of June 30, 2012 included Indirect Allocations and Training. Indirect Allocations included defining costing methodologies based on SCVMC's requirements, developing indirect cost measurement types and assigning values to all direct departments for each type, assigning a measurement type to all indirect departments, identifying direct departments that indirect department costs are to be allocated to, and assigning product allocation structure for all direct departments. It was determined that OI would include the Medicare cost Report adjustments where appropriate to match revenue and expenses for proper unit cost calculations. Training included Cost Accounting Concepts training sessions for the RVU participants (cost center managers and other key staff). Half of the scheduled Cost Accounting Concepts training sessions were completed by June 30, 2012.

Category 2: Redesign for Cost Containment

The senior financial analyst that was budgeted to work on this initiative was hired in March 2012 and started work in April 2012. An additional finance resource was also assigned to the project. The finance project team includes both staff. They will become in-house cost accounting resources when the knowledge transfer is completed.

OI presented at Division Managers on May 22, 2012. Their presentation was a version of the training materials and meant to be an introduction to the methodology and process.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	* Yes
Achievement Value	0.75

Process Milestone:	2. Develop/identify a cost accounting methodology to quantify the financial impact of quality and efficiency improvement interventions.
	(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

The foundation for this milestone, cost accounting methodology, was established in Milestone 1. This Milestone is shown at 100%. The development of the metrics is complete. Our systems and staff are ready to generate the metrics (e.g., average cost per case for each hospital bed day for chosen specific clinical conditions; average annual cost of hospitalization for chosen specific primary diagnoses clinical conditions) for diabetes care, the top 20 MS –DRGs, and the metrics associated with Category III and 4 initiatives.

The process of defining the metrics with the initiative leads started in September 2011. Meetings were held with Category 4 initiative leads. These were introductory meetings with the departments to lay the ground work for metric development to measure their initiatives results, as well as the RVU development meetings later in the project. Discussions included metrics, the general approach for the cost containment initiative, and identifying the patient population. Further meetings will be held to add additional metrics that will be used for each initiative once the cost accounting data is available.

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

Category 2: Redesign for Cost Containment

Process Milestone: 3. Establish a baseline for cost
(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]

> DY 6 was chosen as the base year. Work to develop the baseline cost started in January 2012 and continued through June 2012. Many of the tasks have been completed or are in progress, and are described in Milestone 1.
>
> This Milestone is shown at 50% complete. It is contingent upon completion of Milestone 1. The completion of the remaining tasks in the project timeline will enable the baseline unit cost and metric reports required in this milestone to be generated.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [Yes]

Achievement Value [0.50]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * [ ]

Denominator (if absolute number, enter "1") * [ ]

Achievement [N/A]

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: * [ ]

> [ ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [ ]

Achievement Value [ ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * [ ]

Denominator (if absolute number, enter "1") * [ ]

Achievement [N/A]

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: * [ ]

> [ ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [ ]

Achievement Value [ ]

Category 2: Redesign for Cost Containment

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

DSRIP Semi-Annual Reporting Form

Category 2: Redesign for Cost Containment

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

Achievement | N/A |

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: *

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

Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

Achievement | N/A |

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: *

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

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * | Yes |

Category 2: Integrate Physical and Behavioral Health Care

Below is the data reported for the DPH system.
Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).
* ☐ The yellow boxes indicate where the DPH system should input data
    ■ The black boxes indicate Milestones and will automatically populate and flow to summary sheets
    ☐ The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
    populate and flow to summary sheets

Integrate Physical and Behavioral Health Care

DY Total Computable Incentive Amount: * \$ 14,500,000.00

Incentive Funding Already Received in DY: * \$ 4,833,333.33

Process Milestone: 1. Implement IMPACT training of behavioral health and primary care staff within four primary care settings.
                               (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

Overview

With the onset of the 2nd year (DY7) of the Category 2 DSRIP Project: Integrate Physical and Behavioral Health, Santa Clara County (SCC) Mental Health Department (MHD) and Ambulatory Care Services (ACS) continued work on the integration of newly embedded psychiatrists and clinical social workers within several FQHC Clinics. Year 1 (DY6) was spent on key administrative issues concerning embedding 19.5 FTE Licensed Clinical Social Workers (LCSWs) and 8.0 FTE Psychiatrists into four primary care (PC) clinics. Year 2 focused on clarifying roles, unifying leadership, launching the IMPACT training, and expanding   behavioral health (BH) services to patients, and absorbing an additional 6.5 FTE Psychiatrists and 4.5 FTE Licensed Psychiatric Technicians transferred into the practice. The three milestones for Year 2 were:

Milestone1: Implement IMPACT Training of behavioral health and four primary care settings

Milestone 2: 500 primary care patients will be provided behavioral health service by end of Year 2

Milestone3:   Design, test and finalize protocol for patient referral process into FQHC-BH service

Key to achieving Year 2 (DY7) milestones was formalizing the contract with the University of Washington to use the IMPACT model as the framework around which to integrate care and to identify policies that define the primary care-based behavioral health practice. This included refining the internal referral protocol between PC and BH FQHC practitioners; as well as between the FQHC clinics and the MHD specialty system.

During the first six months of Year 2 DY7) the MHD and ACS worked through the challenges resulting from considerable changes in the leadership of both organizations. In addition, several organizational changes were implemented by the MHD to support this effort more fully through the creation of a new division- the Division of Integrated Behavioral Health within the MHD. This new Division includes a dedicated Division Director to work with ACS to address the numerous operational, quality, and policy issues that are related to incorporating the new BH service within the PC clinic environment. Additionally, the MHD provided a dedicated manager to lead the training and technical implementation efforts.

Category 2: Integrate Physical and Behavioral Health Care

Given the scope of the integration, some key accomplishments realized in FY 11-12 included:

• Identifying and securing agreement on the work plan of tasks and programmatic issues needed to be addressed to

insure that BH staffs are fully compliant with PC clinic regulatory and policy requirements.
• Defining the new workflow of the psychiatrists and clinical social workers;
• Defining processes for patient information to be coordinated between PC and BH providers; and
• Creating a new model of practice delivery for psychiatrists and clinical social workers by working in a PC clinic with its business and clinical processes.

By February 2012, dedicated bi-monthly meetings of the BH clinic managers were implemented (these ongoing meetings occur regularly on the 2nd and 4th Weds of the month) and regular meetings have been established between the ACS and MHD senior leadership to shepherd this year-long integration process.

FY 11-12 focused on identifying the data infrastructure needs that will allow for this evaluative component to be feasible before the conversion to a new EMR scheduled to launch July-Sept 2013.
FY 12-13 will be the year in which systematic screening for depression and outcomes tracking will be piloted, and thus, that outcomes and evaluation of the efficacy of the treatments for our patients will be available.

MILESTONES

All three DSRIP IMPACT Year 2 (FY 11-12) goals were successfully met by June 30, 2012. Four primary care clinics, Gilroy, Milpitas, Sunnyvale, and Alexian Homeless Clinic, each completed the mandatory IMPACT training by June 30, 2012, with over 50% PC staff participation and 90% BH staff participation. Well over 500 PC patients, (2000 patients in fact), were provided BH services. The patient referral process between PC and BH disciplines was designed with input from all staff. The referral form was tested and finalized and includes a defined protocol for patient referrals.

Milestone: Implement IMPACT Training of behavioral health and four primary care settings.

The first step to completing Milestone 1 this year was to educate the executive and senior ACS and MHD leadership - That nominal training is provided up front as an introduction. The real training occurs during pre-implementation discussions and implementation. The second step was to familiarize staff with IMPACT's principle elements and outcomes by providing a 1-hour Webinar training, followed by team-building activities. The objective was to secure staff buy-in to the model and begin to educate on the difference between collocated and integrated care, and to insure that staff understood the extensive technical assistance support that would be involved throughout the implementation.

The next step was to insure that executive leaders were oriented and enlisted to sponsor the IMPACT Training. To that end, the following meetings occurred:

• 11/8/2011 - Executive leaders from both MHD and ACS and key ACS clinic site leadership staff met to understand
better the IMPACT implementation process.
• 1/30/2012 - Executive MHD and ACS staff viewed the webinar and approved the forms to be used.
• 2/10/2012 - Gilroy and Milpitas clinic leadership (Medical Director and Health Clinic Manager), ACS' Director of Quality, Utilization Management, Ambulatory Care, with the MHD's medical director, behavioral health clinic manager, division director, and implementation project manager met to discuss the concrete work plan for the IMPACT training and technical assistance.
• 4/27/2012 all behavioral health staff attended a two-and-a-half hour overview of integrated behavioral health, and the DSRIP project.

The final step was the completion of the IMPACT Webinar at the four clinic sites. The Webinar trainings were completed at each site on the following dates:

• 2/17/2012 - Milpitas Clinic
• 3/2/2012, 4/11/2012, and 6/15/2012 - Gilroy Clinic
• 4/2/2012 - Sunnyvale Clinic
• 5/9/2012 - Alexian Homeless Clinic

In addition, on 4/27/2012, all BH staff attended a two-and-a-half hour overview of integrated behavioral health, and the DSRIP project.

Category 2: Integrate Physical and Behavioral Health Care

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

Process Milestone:	2. 500 primary care patients will be provided behavioral health services by end of Year Two.

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*
Denominator (if absolute number, enter "1")	*
Achievement	N/A

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: *

Milestone: 500 primary care patients will be provided behavioral health service by end of Year

As shown in this report, our system exceeded the goal of providing BH services to 500 primary care patients.

The aim of the SCVHHS (Santa Clara Valley Health and Health System) integrated PC/BH is to provide improved responses to: 1) the PC needs of patients with chronic psychiatric conditions, and 2) the BH needs of patients who currently have limited to no access to BH services. The emerging profile of patients being served in the PC/BH clinics can be categorized into four populations of patients from the perspective of behavioral health need:

1. Patients with no or minimal BH concerns who are currently served appropriately by their PC, and who will benefit from the added resource of BH consultation and prevention resources- added in Year 2;

2. Patients with episodic BH needs who have the opportunity to receive brief treatment, medication management, and consultation services to PC providers through the added resource of the BH staff- added in Year 2;

3. Patients with chronic psychiatric conditions with complex medication management need who are appropriately served within a PC setting with psychiatric medication management support; and access to focused and time-limited clinical interventions when indicated; and,

4. Patients with chronic psychiatric conditions with complex medication management and specialized mental health service needs who are appropriately served within a PC setting for medical care, psychiatric medication management and clinical care; and who are provided medically necessary specialty mental health services through co-located and/or community based services through the specialty mental health system.

The first phase of implementation focused on patients in groups #3 and #4 above. These patients, previously or currently served in the specialty mental health system, have moderate psychiatric conditions. They have been connected with a psychiatrist that provides ongoing psychiatric medication management within the PC clinic. Many of these patients were already patients of the psychiatrists moved to the PC clinic from the specialty clinics, and are now better served through the seamless coordination of their psychiatric and medical care needs.

Many of these patients have had specialty services such as case management, peer support, and access to crisis and residential support services. Those services may continue to be provided through the specialty system when indicated by medical necessity. The goal is to establish these clients who are in the recovery and maintenance phase of their mental illness within one of the new PC/BH clinics to insure ongoing integrated medical and psychiatric care. Because the PC and specialty clinics were co-located prior to the integration of most of the psychiatrists and clinical social workers, the change has been seamless for most patients. The greatest challenge has been for the psychiatrists and

clinicians, who are learning to adapt to the business and clinical processes as they transition to the PC clinic requirements. The greatest benefit from this phase has been the psychiatric patients' access to a PC medical home and to better coordinated healthcare.

The second phase of implementation was to focus on group #2 above, and to establish the protocols for the referral of patients between physicians and BH resources now available within the new integrated PC environments. During this phase, the MHD also established a new resource through their call center, which provides access to PC- based BH service for those individuals who do not qualify for the Specialty Mental Health system and who do not have a PC provider.

This phase has involved meetings between the physicians and clinical staff to outline how psychiatric and medical care needs of the expanded clinic population would be identified and addressed. This includes how patients who were primarily served by psychiatrists would be linked to PC physicians; how patients who were primarily served by PC physicians would be linked to psychiatric services; and how the specialty mental health system services provided through the MHD would be available to those patients with intensive specialty service needs.

During both phases of Year 2 (DY7) implementation, caseload and visit standards were established for the

Category 2: Integrate Physical and Behavioral Health Care

psychiatrists and the clinicians. It was determined that 30% of psychiatry and 50% of clinical time was available for new referrals from PC providers or the MHD call center. Weekly visit reports by clinician and psychiatrist were created. Clinic BH managers and the Outpatient Psychiatry Medical Director were responsible for tracking BH productivity and working with BH staff

to insure optimal service delivery.

The following graph shows the 5,618 PC patients by ethnicity provided BH service within the four newly integrated PC/BH clinics .
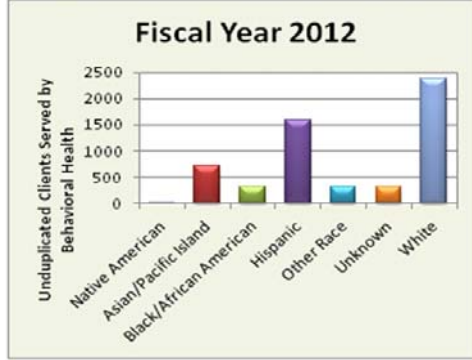
DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	* Yes
Achievement Value	1.00

Category 2: Integrate Physical and Behavioral Health Care

Process Milestone:	3. Design, test, and finalize protocol for patient referral process into Federally Qualified Health Centers (FQHC)-BH services.

(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]

During the DY7 period, clinic management for ACS and BH staff defined standards for referrals from PC to BH services, developed a protocol of how to refer, and created referral tools. During this time, a continual improvement process was used until all staff agreed that a standard was achieved that was beneficial for both PC and BH providers. Over a course of four months, February through June 2012, SCVMC conducted a review of the referral process improvement effort that had been underway since September 2011. By March 2012, the existing referral protocol in use was documented and formalized. By this point, referral parameters had been established (any patient a PCP deemed appropriate), a patient referral form had been tested, revised, and a final form adopted, and the referral process was clearly understood across five clinic sites, the four that received the IMPACT webinar training, plus a fifth clinic, East Valley.

In order to document the patient referral protocol, two in-depth interviews were conducted with staff of two of the five clinics. This was accomplished in a four-step process:
 • Extensive questions on referral parameters, concrete steps in the referral process, time to service from referral, and other considerations, were conducted on 3/16/2012 and 4/18/2012. These interviews included a variety of staff.
 • Findings were shared and discussed with senior management of ACS and MHD to consider systematic considerations, and to gain approval.
 • Findings were discussed and vetted with the BH Managers, MHD Medical Director, Primary Care Medical Director, and Division Director of IBH.
 • The protocol was written out and shared with clinic leadership.

Our ongoing work is ensuring that we will have a standardized workflow for the new integrated care model of IMPACT. Some of the issues to address in DY8 include the following:

 • Transitioning from one electronic medical records system to a new one (HealthLink).
 • Systematic depression screening and outcomes tracking will be piloted to help identify adjustments needed before broader expansion throughout the system.
 • The new electronic health record (EHR) will go into effect for PC starting in July 2013, with BH's EHR activation beginning a few months later, requiring a brief period of work around.
 • The data infrastructure to be used, and new registry function will be trialed and refined to be able to provide an evaluation of the improved patient outcomes.
 • Creating and finalizing the needed comprehensive policies and protocols developed for BH, ensuring that they reflect the practice standards for collaborative and integrated PC/BH care. Given the process in place, it may requires more than 12 calendar months to complete all work, and secure all necessary approvals and signatures.
 • Identifying the best workflow given the current systems constraints and staff shortages: PC providers,

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone *[Yes]

Achievement Value [1.00]

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * [_____]

Category 2: Increase Specialty Care Access/Redesign Referral Process

Below is the data reported for the DPH system.
*Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).*
* ☐ The yellow boxes indicate where the DPH system should input data
☐ The black boxes indicate Milestones and will automatically populate and flow to summary sheets
☐ The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
populate and flow to summary sheets

Increase Specialty Care Access/Redesign Referral Process

DY Total Computable Incentive Amount: * [_____]

Incentive Funding Already Received in DY: * [_____]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * [_____]

Denominator (if absolute number, enter "1") * [_____]

Achievement [N/A]

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: * [_____]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [_____]

Achievement Value [_____]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * [_____]

Denominator (if absolute number, enter "1") * [_____]

Achievement [N/A]

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: * [_____]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [_____]

Achievement Value [_____]

DSRIP Semi-Annual Reporting Form

Category 2: Increase Specialty Care Access/Redesign Referral Process

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement | N/A |

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: *

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

Achievement Value

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement | N/A |

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: *

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

Achievement Value

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement | N/A |

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: *

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

Achievement Value

5/31/2013   Specialty Care Access   130 of 213

Category 2: Increase Specialty Care Access/Redesign Referral Process

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

DSRIP Semi-Annual Reporting Form

Category 2: Increase Specialty Care Access/Redesign Referral Process

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   `*` [   ]

Denominator (if absolute number, enter "1")   `*` [   ]

   Achievement   [N/A]

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: `*` [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   `*` [   ]

   Achievement Value   [   ]

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   `*` [   ]

Denominator (if absolute number, enter "1")   `*` [   ]

   Achievement   [N/A]

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: `*` [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   `*` [   ]

   Achievement Value   [   ]

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * [   ]

Category 2: Establish/Expand a Patient Care Navigation Program

Below is the data reported for the DPH system.
*Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).*

* ☐ The yellow boxes indicate where the DPH system should input data
☐ The black boxes indicate Milestones and will automatically populate and flow to summary sheets
☐ The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
populate and flow to summary sheets

Establish/Expand a Patient Care Navigation Program

DY Total Computable Incentive Amount: * [   ]

Incentive Funding Already Received in DY: * [   ]

Process Milestone: _____
                                        (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

   Achievement Value   [   ]

Process Milestone: _____
                                        (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

   Achievement Value   [   ]

Category 2: Establish/Expand a Patient Care Navigation Program

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [ ]

Denominator (if absolute number, enter "1")   * [ ]

Achievement   [N/A]

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: * [ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [ ]

Achievement Value   [ ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [ ]

Denominator (if absolute number, enter "1")   * [ ]

Achievement   [N/A]

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: * [ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [ ]

Achievement Value   [ ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [ ]

Denominator (if absolute number, enter "1")   * [ ]

Achievement   [N/A]

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: * [ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [ ]

Achievement Value   [ ]

Category 2: Establish/Expand a Patient Care Navigation Program

Improvement Milestone: _____
                                                    (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

Improvement Milestone: _____
                                                    (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

Improvement Milestone: _____
                                                    (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

DSRIP Semi-Annual Reporting Form

Category 2: Establish/Expand a Patient Care Navigation Program

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * ▯

Denominator (if absolute number, enter "1") * ▯

Achievement | N/A |

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: * ▯

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * ▯

Achievement Value | |

Improvement Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * ▯

Denominator (if absolute number, enter "1") * ▯

Achievement | N/A |

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: * ▯

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * ▯

Achievement Value | |

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * [   ]

Category 2: Apply Process Improvement Methodology to Improve Quality/Efficiency

Below is the data reported for the DPH system.
*Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).*
* [ ] The yellow boxes indicate where the DPH system should input data
[ ] The black boxes indicate Milestones and will automatically populate and flow to summary sheets
[ ] The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
populate and flow to summary sheets

Apply Process Improvement Methodology to Improve Quality/Efficiency

DY Total Computable Incentive Amount: * [   ]

Incentive Funding Already Received in DY: * [   ]

Process Milestone: _____
                              (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

   Achievement Value   [   ]

Process Milestone: _____
                              (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

   Achievement Value   [   ]

Category 2: Apply Process Improvement Methodology to Improve Quality/Efficiency

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

   Achievement | N/A |

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: *

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

   Achievement Value

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

   Achievement | N/A |

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: *

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

   Achievement Value

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

   Achievement | N/A |

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: *

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

   Achievement Value

Category 2: Apply Process Improvement Methodology to Improve Quality/Efficiency

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * ▭

Denominator (if absolute number, enter "1") * ▭

   Achievement N/A

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: * ▭

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * ▭

   Achievement Value ▭

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * ▭

Denominator (if absolute number, enter "1") * ▭

   Achievement N/A

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: * ▭

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * ▭

   Achievement Value ▭

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * ▭

Denominator (if absolute number, enter "1") * ▭

   Achievement N/A

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: * ▭

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * ▭

   Achievement Value ▭

Category 2: Apply Process Improvement Methodology to Improve Quality/Efficiency

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * [ ]

Category 2: Improve Patient Flow in the Emergency Department/Rapid Medical Evaluation

Below is the data reported for the DPH system.
Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).
* [ ] The yellow boxes indicate where the DPH system should input data
 [ ] The black boxes indicate Milestones and will automatically populate and flow to summary sheets
 [ ] The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
 populate and flow to summary sheets

Improve Patient Flow in the Emergency Department/Rapid Medical Evaluation	
DY Total Computable Incentive Amount:	* [ ]
Incentive Funding Already Received in DY:	* [ ]
Process Milestone: _____ *(insert milestone)*	
Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	* [ ]
Denominator (if absolute number, enter "1")	* [ ]
Achievement	N/A
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:	* [ ]
[ ]	
DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	* [ ]
Achievement Value	[ ]
Process Milestone: _____ *(insert milestone)*	
Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	* [ ]
Denominator (if absolute number, enter "1")	* [ ]
Achievement	N/A
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:	* [ ]
[ ]	
DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	* [ ]
Achievement Value	[ ]

Category 2: Improve Patient Flow in the Emergency Department/Rapid Medical Evaluation

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *⬚

Denominator (if absolute number, enter "1") *⬚

   Achievement `N/A`

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: *⬚

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone *⬚

   Achievement Value

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *⬚

Denominator (if absolute number, enter "1") *⬚

   Achievement `N/A`

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: *⬚

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone *⬚

   Achievement Value

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *⬚

Denominator (if absolute number, enter "1") *⬚

   Achievement `N/A`

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: *⬚

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone *⬚

   Achievement Value

Category 2: Improve Patient Flow in the Emergency Department/Rapid Medical Evaluation

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   N/A

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: *

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

   Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   N/A

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: *

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

   Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

   Achievement   N/A

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: *

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

   Achievement Value

Category 2: Improve Patient Flow in the Emergency Department/Rapid Medical Evaluation

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *⬜

Denominator (if absolute number, enter "1")   *⬜

Achievement   N/A

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: *⬜

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   *⬜

Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *⬜

Denominator (if absolute number, enter "1")   *⬜

Achievement   N/A

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: *⬜

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   *⬜

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * [   ]

Category 2: Use Palliative Care Programs

Below is the data reported for the DPH system.
*Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).*
* [ ] The yellow boxes indicate where the DPH system should input data
[ ] The black boxes indicate Milestones and will automatically populate and flow to summary sheets
[ ] The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
populate and flow to summary sheets

Use Palliative Care Programs

DY Total Computable Incentive Amount: * [   ]

Incentive Funding Already Received in DY: * [   ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [   ]

   Achievement Value   [   ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [   ]

   Achievement Value   [   ]

Category 2: Use Palliative Care Programs

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

    Achievement   N/A

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: *

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

    Achievement Value

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

    Achievement   N/A

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: *

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

    Achievement Value

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

    Achievement   N/A

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: *

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

    Achievement Value

Category 2: Use Palliative Care Programs

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

DSRIP Semi-Annual Reporting Form

Category 2: Use Palliative Care Programs

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [ ]

Denominator (if absolute number, enter "1")   * [ ]

   Achievement   [N/A]

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: * [ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [ ]

   Achievement Value   [ ]

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [ ]

Denominator (if absolute number, enter "1")   * [ ]

   Achievement   [N/A]

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: * [ ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [ ]

   Achievement Value   [ ]

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * [   ]

Category 2: Conduct Medication Management

Below is the data reported for the DPH system.
Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).
* [ ] The yellow boxes indicate where the DPH system should input data
[ ] The black boxes indicate Milestones and will automatically populate and flow to summary sheets
[ ] The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically populate and flow to summary sheets

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Conduct Medication Management

DY Total Computable Incentive Amount: * [   ]

Incentive Funding Already Received in DY: * [   ]

Process Milestone: _____
                                              (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

　　Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

　　Achievement Value   [   ]

Process Milestone: _____
                                              (insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

　　Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

　　Achievement Value   [   ]

Category 2: Conduct Medication Management

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * ☐

Denominator (if absolute number, enter "1")   * ☐

   Achievement   N/A

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: * ☐

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * ☐

   Achievement Value   ☐

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * ☐

Denominator (if absolute number, enter "1")   * ☐

   Achievement   N/A

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: * ☐

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * ☐

   Achievement Value   ☐

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * ☐

Denominator (if absolute number, enter "1")   * ☐

   Achievement   N/A

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: * ☐

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * ☐

   Achievement Value   ☐

DSRIP Semi-Annual Reporting Form

Category 2: Conduct Medication Management

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

Category 2: Conduct Medication Management

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * [   ]

Denominator (if absolute number, enter "1") * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [   ]

Achievement Value   [   ]

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * [   ]

Denominator (if absolute number, enter "1") * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [   ]

Achievement Value   [   ]

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * [   ]

Category 2: Implement/Expand Care Transitions Programs

Below is the data reported for the DPH system.
*Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).*

* [   ] The yellow boxes indicate where the DPH system should input data

[■] The black boxes indicate Milestones and will automatically populate and flow to summary sheets

[   ] The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
populate and flow to summary sheets

Implement/Expand Care Transitions Programs

DY Total Computable Incentive Amount: * [   ]

Incentive Funding Already Received in DY: * [   ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

   Achievement Value   [   ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

   Achievement Value   [   ]

Category 2: Implement/Expand Care Transitions Programs

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * [   ]

Denominator (if absolute number, enter "1") * [   ]

Achievement [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [   ]

Achievement Value [   ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * [   ]

Denominator (if absolute number, enter "1") * [   ]

Achievement [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [   ]

Achievement Value [   ]

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * [   ]

Denominator (if absolute number, enter "1") * [   ]

Achievement [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [   ]

Achievement Value [   ]

DSRIP Semi-Annual Reporting Form

Category 2: Implement/Expand Care Transitions Programs

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement | N/A |

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: *

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

Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement | N/A |

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: *

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

Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement | N/A |

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: *

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

Achievement Value

Category 2: Implement/Expand Care Transitions Programs

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement | N/A |

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: *

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

Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement | N/A |

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: *

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

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM:　　　　　　　Santa Clara Valley Medical Center
REPORTING YEAR:　　　　　DY 7
DATE OF SUBMISSION:　　　9/28/2012

REPORTING ON THIS PROJECT: *

Category 2: Implement Real-Time Hospital-Acquired Infections (HAIs) System

Below is the data reported for the DPH system.
*Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).*

* ☐ The yellow boxes indicate where the DPH system should input data
  ■ The black boxes indicate Milestones and will automatically populate and flow to summary sheets
  ☐ The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
  populate and flow to summary sheets

Implement Real-Time Hospital-Acquired Infections (HAIs) System

DY Total Computable Incentive Amount: *

Incentive Funding Already Received in DY: *

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

　Achievement　　　　　　　　　　　　　　　　　　　　　　N/A

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: *

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

　Achievement Value

Process Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

　Achievement　　　　　　　　　　　　　　　　　　　　　　N/A

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: *

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

　Achievement Value

Category 2: Implement Real-Time Hospital-Acquired Infections (HAIs) System

Process Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

Process Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

Process Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

DSRIP Semi-Annual Reporting Form

Category 2: Implement Real-Time Hospital-Acquired Infections (HAIs) System

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *[ ]

Denominator (if absolute number, enter "1") *[ ]

Achievement [N/A]

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: *[ ]

[ ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone *[ ]

Achievement Value [ ]

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *[ ]

Denominator (if absolute number, enter "1") *[ ]

Achievement [N/A]

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: *[ ]

[ ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone *[ ]

Achievement Value [ ]

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *[ ]

Denominator (if absolute number, enter "1") *[ ]

Achievement [N/A]

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: *[ ]

[ ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone *[ ]

Achievement Value [ ]

DSRIP Semi-Annual Reporting Form

Category 2: Implement Real-Time Hospital-Acquired Infections (HAIs) System

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   `N/A`

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: *

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

Achievement Value

Improvement Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   `N/A`

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: *

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

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012
Category 3: Patient/Care Giver Experience *(required)*

Below is the data reported for the DPH system.
** Instructions for DPH systems: Please type in all of your DY milestones for the project below and report data
in the indicated boxes (*). Note: for DY8, data from the last 2 quarters shall suffice.*
* The yellow boxes indicate where the DPH system should input data
    The black boxes indicate Milestones and will automatically populate and flow to summary sheets
    The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
    populate and flow to summary sheets

Patient/Care Giver Experience (required)

DY Total Computable Incentive Amount:	* $ 6,327,750.00
Incentive Funding Already Received in DY:	* $ 3,163,875.00

**Undertake the necessary planning, redesign, translation, training and contract
negotiations in order to implement CG-CAHPS in DY8 *(DY7 only)***

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is
assumed for applicable DY. If so, please explain why data is not available):   * Yes

Goal

The DY7 goal for this milestone is to identify the scope of CG-CAHPS implementation at Santa Clara Valley Medical
Center and accomplish all necessary plans, contracts, and training prior to the start of data collection in DY8.

Process

On June 7, 2011, Santa Clara Valley Medical Center participated with other health system representatives in a
conversation sponsored by California Public Hospitals (CAPH) and the Safety Net Institute (SNI) regarding the
implementation of CG-CAHPS. The goal was to identify a single, coordinated approach to administering the CG-CAHPS
survey across the California Public Hospital membership. The resulting group recommendations identified a minimum
baseline of standardization for the survey type, administration modes, survey languages, and population. It was also
agreed that a minimum sampling of 300 completed surveys per year would be reported at the health system level.

Santa Clara Valley Medical Center subsequently conducted internal discussions to define the reporting level, survey
scope, and sampling strategy appropriate for the institution. Medical leadership was persuasive in its support for provider-
level sampling, and executive leadership identified funding to support implementation of the survey at this level.
Executive leadership also made the determination to broaden the survey scope from Primary Care services to include all
ambulatory clinic sites. The approved plan calls for conducting fifty interviews per provider.

Santa Clara Valley Medical Center was fortunate in having an established vendor relationship with Professional
Research Consultants (PRC). Updates were made to the existing contract and the RFP process was initiated to explore
other vendor options.

The Medical Director presented information on CG-CAHPS implementation to providers at a Quarterly Staff Meeting, and
a similar presentation was made to all ambulatory health center managers.

Challenges

The biggest challenge in planning the implementation of CG-CAHPS was identifying an accurate sampling frame for
patient sampling at the provider level. Multiple strategies were reviewed, and we anticipate a decision soon. However, if
necessary, Santa Clara Valley Medical Center has identified appropriate sampling methodology to implement CG-
CAHPS at the clinic level.

Achievement	Yes
Achievement Value	1.00

**Report results of CG CAHPS questions for "Getting Timely Appointments, Care,
and Information" theme to the State *(DY8-10)***

Top-box score composite of all questions within this theme from all returned surveys:
Enter the percentage of responses that fell in the most positive response category   *

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is

Category 3: Patient/Care Giver Experience *(required)*

assumed for applicable DY. If so, please explain why data is not available):

| Achievement | N/A |
| Achievement Value | |

Category 3: Patient/Care Giver Experience *(required)*

Report results of CG CAHPS questions for "How Well Doctors Communicate With Patients" theme to the State *(DY8-10)*

Top-box score composite of all questions within this theme from all returned surveys:
Enter the percentage of responses that fell in the most positive response category

* [   ]

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

[   ]

Achievement   [N/A]

Achievement Value   [   ]

Report results of CG CAHPS questions for "Helpful, Courteous, and Respectful Office Staff" theme to the State *(DY8-10)*

Top-box score composite of all questions within this theme from all returned surveys:
Enter the percentage of responses that fell in the most positive response category

* [   ]

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

[   ]

Achievement   [N/A]

Achievement Value   [   ]

Report results of CG CAHPS questions for "Patients' Rating of the Doctor" theme to the State *(DY8-10)*

Top-box score composite of all questions within this theme from all returned surveys:
Enter the percentage of responses that fell in the response categories 9 and 10

* [   ]

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

[   ]

Achievement   [N/A]

Achievement Value   [   ]

Category 3: Patient/Care Giver Experience *(required)*

Report results of CG CAHPS questions for "Shared Decisionmaking" theme to the State *(DY8-10)*

Top-box score composite of all questions within this theme from all returned surveys:
Enter the percentage of responses that fell in the most positive response category

*

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

Achievement   N/A

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012
Category 3: Care Coordination *(required)*

Below is the data reported for the DPH system.
* Instructions for DPH systems: Please type in all of your DY milestones for the project below and report data in the indicated boxes (*).
* The yellow boxes indicate where the DPH system should input data
The black boxes indicate Milestones and will automatically populate and flow to summary sheets
The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically populate and flow to summary sheets

Care Coordination (required)

DY Total Computable Incentive Amount:	* $ 6,327,750.00
Incentive Funding Already Received in DY:	* $ 3,163,875.00

Report results of the Diabetes, short-term complications measure to the State (DY7-10)

Data Collection Source	* Data warehouse
Numerator	* 112.0
Denominator	* 5,360.0
Rate	2.1

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

Diabetes, short-term complications is reported for the full year DY7. We include a numerator based on the primary diagnosis of "short-term complications" as well as any priority coding (Primary and secondary diagnoses) . Based on primary diagnosis coding, roughly 2% of patients were admitted for a "short-term complication". We plan to use this metric as a baseline to plan for future interventions and identify the patients who have been admitted, notify their PCP and link them with a diabetes care manager for a goal of reducing the risk of admission.

Only paneled patients that met DSRIP denominator requirements (2 or more primary care visits in the subsequent DY) were included in this metric.

Achievement	Yes
Achievement Value	1.00

Report results of the Uncontrolled Diabetes measure to the State *(DY7-10)*

Data Collection Source	* Data warehouse
Numerator	* 3.0
Denominator	* 5,360.0
Rate	0.1

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

"Uncontrolled Diabetes", is reported for the full year DY7. We include a numerator based on the primary diagnosis of "uncontrolled diabetes" as well as any priority coding (primary and secondary codes). Based on primary diagnosis coding, only 0.06% of patients were admitted for a "uncontrolled diabetes". We believe that this figure significantly underestimates the true admission rate for "uncontrolled diabetes", likely because the ICD-9 codes 250.02 and 250.03 are not frequently used as primary diagnoses in our institution. Our rate was 2.93, based on priority coding.

Because we believe this metric does not truly represent our rate for uncontrolled diabetes in our institution, there is not a plan in place at this time to use it for quality improvement purposes. Only paneled patients that met DSRP denominator requirements (2 or more primary care visits in the subsequent DY) were

Category 3: Care Coordination *(required)*

included in this metric.

Achievement	Yes
Achievement Value	1.00

Category 3: Care Coordination *(required)*

Report results of the Congestive Heart Failure measure to the State *(DY8-10)*

Data Collection Source   *

Numerator   *

Denominator   *

  Rate

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

    Achievement   N/A

    Achievement Value

Report results of the Chronic Obstructive Pulmonary Disease measure to the State *(DY8-10)*

Data Collection Source   *

Numerator   *

Denominator   *

  Rate

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

    Achievement   N/A

    Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

Category 3: Preventive Health *(required)*

Below is the data reported for the DPH system.
* Instructions for DPH systems: Please type in all of your DY milestones for the project below and report data in the indicated boxes (*).*

* ☐ The yellow boxes indicate where the DPH system should input data

☐ The black boxes indicate Milestones and will automatically populate and flow to summary sheets

☐ The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically populate and flow to summary sheets

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Preventive Health (required)

DY Total Computable Incentive Amount:	* $ 6,327,750.00
Incentive Funding Already Received in DY:	* $ 3,163,875.00

Report results of the Mammography Screening for Breast Cancer measure to the State *(DY7-10)*

Data Collection Source	* Data warehouse
Numerator	* 5,799.0
Denominator	* 9,512.0
Rate	61.0

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

Milestone was achieved in DY7. The mammography screening rates for breast cancer were determined by identifying patients within the denominator (to which the additional criteria of paneled was added) and then comparing this against data from our Diagnostic Imaging systems to determine if the patients in the denominator had a mammogram, establishing the denominator as 9512. Our data reflects the numerator as 5,799 which indicates 61% of patients had a mammogram. As with the other Category 3 measures, this work was conducted by a group of staff including data analysts, clinicians, and ambulatory care leaders.

The data are used for the following activities based on the Ambulatory Quality Plan:

• offer preventive care services under protocol,
• follow patients who have abnormal mammograms
• maintain communication with the paneled provider of results.
• ordering of biopsies to be a collaboration between Diagnostic Imaging, Surgery Clinic and the pt's
  paneled provider

Efficiency and effectiveness of the expanded role of the Centralized Registry to be determined. Corrective actions for identified areas of improvement will result in the revision of the protocol.

Achievement	Yes
Achievement Value	1.00

Reports results of the Influenza Immunization measure to the State *(DY7-10)*

Data Collection Source	* Data warehouse
Numerator	* 5,382.0
Denominator	* 16,293.0
Rate	33.0

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

Milestone was achieved in DY7.   The most significant caveat to this milestone is that as the availability of influenza vaccines has increased at convenient locations such as local drug stores, more of our patients receive this vaccine outside of our system. As a result, our system vaccination numbers will be lower

Category 3: Preventive Health *(required)*

than the actual rates of vaccination among our patients. When patients report that they have received an influenza vaccine outside of our system, it is entered into the notes section of the patient's electronic medical record; however, that information is not accessible for reporting at this time. We plan to explore options to access this information.

Based on vaccinations given at SCVMC service locations only, 33% of our patients identified in the denominator (16,293 individuals) received a flu vaccine during the period 7/1/2011 – 6/30/2012.

Achievement	Yes
Achievement Value	1.00

DSRIP Semi-Annual Reporting Form

Category 3: Preventive Health *(required)*

Report results of the Child Weight Screening measure to the State *(DY8-10)*

Data Collection Source   *

Numerator   *

Denominator   *

  Rate

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

Achievement   N/A

Achievement Value

Report results of the Pediatrics Body Mass Index (BMI) measure to the State *(DY8-10)*

Data Collection Source   *

Numerator   *

Denominator   *

  Rate

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

Achievement   N/A

Achievement Value

Report results of the Tobacco Cessation measure to the State *(DY8-10)*

Data Collection Source   *

Numerator   *

Denominator   *

  Rate

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

Achievement   N/A

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

Category 3: At-Risk Populations *(required)*

Below is the data reported for the DPH system.
* Instructions for DPH systems: Please type in all of your DY milestones for the project below and report data in the indicated boxes (*). For the last two measures, which are both diabetes composite measures, please follow the instructions on specifically how to calculate the composite measures (available based on NQF endorsement).

*   The yellow boxes indicate where the DPH system should input data

    The black boxes indicate Milestones and will automatically populate and flow to summary sheets

    The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically populate and flow to summary sheets

At-Risk Populations (required)

DY Total Computable Incentive Amount:	* $ 6,327,750.00
Incentive Funding Already Received in DY:	* $ 3,163,875.00

Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State *(DY7-10)*
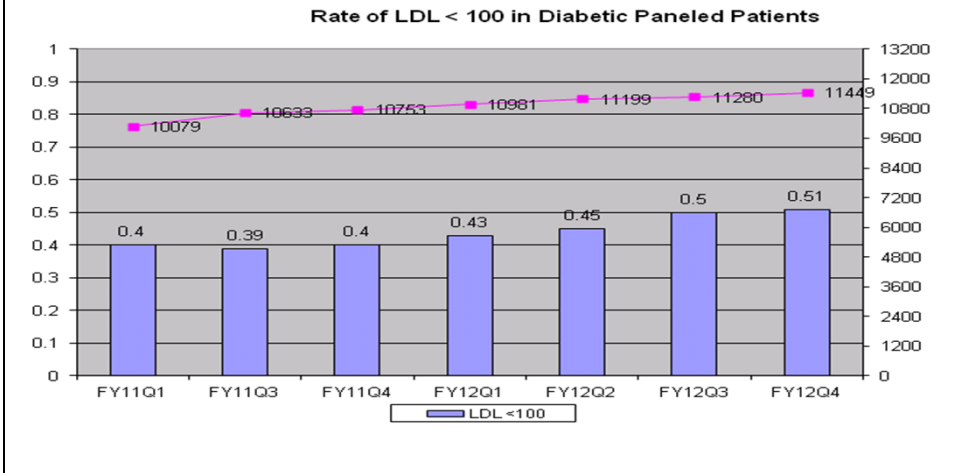
Data Collection Source	* Registry
Numerator	* 3,330.0
Denominator	* 5,360.0
Rate	62.0

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

The denominator of 5360 for this measure was derived in the same manner as the denominators for all the diabetes measures for DY 7. The numerator of 3330 consists of patients whose most recent LDL-C level (in the reporting period) was less than 100mg/dL. This information was derived from our laboratory data system which feeds data into our electronic registry (Filemaker Pro). For the period 7/1/2011 – 6/30/2012, 62% (3330 patients out of 5360) had their most recent LDL level in control, which is roughly 10% higher than our data for ALL paneled patients. This difference is likely due to the fact that the "DSRIP" population is likely more engaged in our health care system based on the two-visit minimum visit requirement in the denominator definition.

We have been working for the past year on several strategies to improve both LDL-screening and control, including developing and distributing "exception" reports in our registry to identify patients due for LDL-screening, establishing processes for diabetes care management teams to "outreach" to patients due for LDL-screening.

Below is a figure showing the improved LDL-control in all of our paneled patients over the past 2 years.

Rate of LDL < 100 in Diabetic Paneled Patients

Category 3: At-Risk Populations *(required)*

Achievement	Yes
Achievement Value	1.00

Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<8%) measure to the State *(DY7-10)*

Data Collection Source	*	Registry
Numerator	*	3,611.0
Denominator	*	5,360.0
Rate		67.0

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

The two measures in the At-Risk population section were reviewed and validated by the same group of clinicians, data analysts, and ambulatory leaders identified in previous Category III metric narratives. The denominator of 5360 for this measure was derived in the same manner as the denominators for all the diabetes measures for DY7. The numerator of 3611 consists of patients whose most recent A1c (in the reporting period) was less than 8%. This information was derived from our laboratory data system which feeds data into our electronic registry (Filemaker Pro). For the period 7/1/2011 – 6/30/2012, 67% (3611 patients out of 5360) had their most recent A1c level in control, which is roughly 15% higher than our data for ALL paneled patients. This difference is likely due to the fact that the "DSRIP" population is likely more engaged in our health care system based on the two-visit minimum visit requirement in the denominator definition. We have been working for the past year on several strategies to improve both A1c-screening and control, including developing and distributing "exception" reports in our registry to identify patients due for A1c-screening, and establishing processes for diabetes care management teams to "outreach" to patients due for A1c-screening.

Below is a figure showing the improved A1c-control in all of our paneled patients over the past 2 years.

Rate of A1C <9% & A1C <8% in VMC-Paneled Patients with Diabetes

Achievement	Yes
Achievement Value	1.00

DSRIP Semi-Annual Reporting Form

Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State *(DY8-10)*

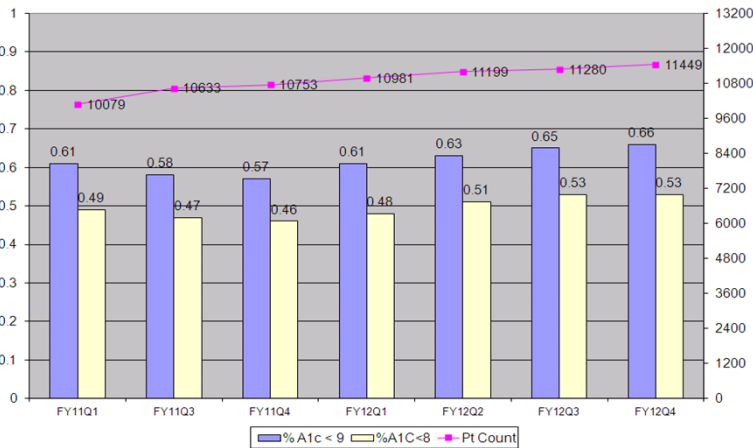Data Collection Source `*`

Numerator `*`

Denominator `*`

Rate

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

Achievement `N/A`

Achievement Value

Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State *(DY8-10)*

Data Collection Source `*`

Numerator `*`

Denominator `*`

Rate

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

Achievement `N/A`

Achievement Value

Report results of the Pediatrics Asthma Care measure to the State *(DY8-10)*

Data Collection Source `*`

Numerator `*`

Denominator `*`

Rate

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

Achievement `N/A`

Achievement Value

Category 3: At-Risk Populations *(required)*

DSRIP Semi-Annual Reporting Form

Report results of the Optimal Diabetes Care Composite to the State *(DY8-10)*

Data Collection Source　　*

Numerator　　*

Denominator　　*

　Rate

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

　Achievement　　　　N/A

　Achievement Value

Report results of the Diabetes Composite to the State *(DY8-10)*

Data Collection Source　　*

Numerator　　*

Denominator　　*

　Rate

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

　Achievement　　　　N/A

　Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR:
DATE OF SUBMISSION:
Category 4: Severe Sepsis Detection and Management *(required)*

Below is the data reported for the DPH system.
* Instructions for DPH systems: Please type in all of your DY milestones for the project below and report data
in the indicated boxes (*).

* ☐ The yellow boxes indicate where the DPH system should input data
☐ The black boxes indicate Milestones and will automatically populate and flow to summary sheets
☐ The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
    populate and flow to summary sheets

Severe Sepsis Detection and Management

DY Total Computable Incentive Amount:	* $ 3,569,500.00
Incentive Funding Already Received in DY:	* $ 3,371,194.44

Compliance with Sepsis Resuscitation bundle (%)

Numerator	* 349
Denominator	* 874
% Compliance	0.40

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

The compliance ratio for DY7 (July 1, 2011 to June 30, 2012) was 40%. Our Total Bundle Compliance ratio reflects how many patients received all 4 elements of the bundle over how many patients met the population criteria to receive the bundle. We used Time of Screening (TOS) or Time of Presentation (TOP) of Sepsis/Severe Sepsis/Septic Shock who met the population criteria to get our values. TOP is defined as the time that the Physician made a notation of possible Sepsis/Severe Sepsis/Septic Shock in the History and Physical, or the time that all of the signs/symptoms that define Severe Sepsis or Septic Shock were present. The four elements of the Resuscitation Bundle are defined as: lactate drawn within 4 hours before or 6 hours after TOS or TOP, blood cultures drawn before an antibiotic is given, broad spectrum antibiotic given IV within 1 hr of TOS or TOP for Inpatient or within 3 hr of TOS or TOP for ED, and an IV fluid bolus of at least 20mL/kg or 1000mL of crystalloid or 300-500mL of colloid within 6hrs of TOS or TOP. We did not have an official Sepsis Screening Tool in place for this time frame, however we were in the Pilot Phase for testing several Screening Tools in five units (starting in ED 2/20/12 and 4 Inpatient areas 3/19/12).

DY Target (from the DPH system plan, if appropriate)	*
% Achievement of Target	Yes
Achievement Value	1.00

Optional Milestone: 1. Establish which parameters for data monitoring for Severe Sepsis will be utilized.

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*
Denominator (if absolute number, enter "1")	*
Achievement	

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

Data monitoring criteria established July 2011.

This milestone was complete with our first half DY 7 report. We did manual retrospective chart reviews and used TOP of Sepsis/Severe Sepsis/Septic Shock or the time that all of the signs/symptoms that define Severe Sepsis or Septic Shock were present, and then applied the exclusion criteria. We did not have a Screening Tool in place at this time. The population criteria we used were based on INLP (Integrated Nurse Leadership Project) definitions: All patients presenting to the ED, or inpatients 18 years and older with the following exclusions: OB patients, patients transferred from an outside facility with Severe Sepsis/Septic Shock, patients that are DNR (do not resuscitate), DNI (do not intubate), Comfort Care or Palliative Care on admission or ordered within 24 hrs of TOP of Severe Sepsis/Septic Shock, and patients who signed out

AMA (against medical advice), left the ED without being seen, or who refuse care. The DSRIP Sepsis Steering Committee (aka Sepsis Committee), which is comprised of Physicians and Nurses from multiple disciplines, Staff Developers, Pharmacists, Lab, Data Analysts, and a Quality Improvement Coordinator, meet monthly to share best practices, evaluate progress, and develop the Sepsis Program here at SCVMC. In 2011, they developed a Sepsis Chart Review Check List that outlined how to abstract the required information and maintain data integrity. A lot has transpired within the Sepsis Category since we established our criteria in July 2011. Now in 2012, we face the challenge of keeping our baseline data relevant as all the opinions and decisions from within the Sepsis Collaborative are addressed. As our own education and

Category 4: Severe Sepsis Detection and Management *(required)*

training is enhanced through participation in the SNI Collaborative, reading research articles, and Sepsis Committee meetings, our program is evolving. Our Chart Review Check List has been polished to be more in line with the SNI Sepsis Data Collection Flow Diagram, which help us maintain strict definitions and data integrity. In order to ensure accurate data, we have centralized data collection at the Quality Department (DSRIP team), and decreased the amount of staff performing the data abstractions. As a result of these improvements, our data timelines are more consistent and contain additional information, which gives us a more complete representation of our performance. Although the improvements in the current data collection methods are slightly different than our baseline data collection methods, we do not believe these small differences alter our overall performance with the four elements.

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

Category 4: Severe Sepsis Detection and Management *(required)*

Optional Milestone: 2. Arrange dedicated Sepsis RN for retrospective and concurrent chart reviews of all Sepsis/Severe Sepsis/Septic Shock patients.
(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

Sepsis Resource RN assigned in October 2011. This milestone was complete with our first half DY 7 report. Her role continues to expand as our program matures. From October 2011-January 2012, she assisted with retrospective chart reviews and data abstraction. As of May 2012, she has moved into a clinical role. She supports the bedside Nurses with evaluation of patients, responds to RRT (Rapid Response Team) Sepsis Alerts and aids in directing/administration of the Resuscitation Bundle Elements. She rounds daily to follow up on patients that screen positive. She assists the QI Coordinator with staff education and SCVMC's Sepsis Program development. QI Coordinator hired in January 2012. She is the primary lead for retrospective chart reviews and data abstraction. Both are members of the DSRIP Sepsis Steering Committee.

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

Achievement Value   1.00

Optional Milestone: 3. Assign data analyst to help with data management/establishment of a database, and reporting of data to Safety Net Institute SNI/State.
(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

This milestone was complete with our first half DY 7 report. A Data Analyst from Quality Management was assigned in July 2011. She helped to integrate the data abstracted from manual chart review to Excel spreadsheets and trial assimilation of data from Lab and Pharmacy. She created an Access database for Sepsis in December 2011. Two new full time DSRIP specific Data Analysts were hired in April 2012. Our Access database continues to be in a testing phase, used only by one Data Analyst and the Sepsis QI Coordinator at this time. The information that is documented on the Bundle Management Check List (a form developed to track bundle compliance) by the bedside RN is almost identical to the Access database screen. Eventually this is where the all the bundle element compliance information will be input and stored. It is a challenge at this point to get accurate data from the Check List as it has only been a part of the Pilot Phase since February 2012, and not widely used except in the ED. For example, the ED nurses were filling it out for patients that diid not necessarily meet the criteria. For inpatient areas, more emphasis has been put on screening patients and how to document on the Screening Tool and activating the sepsis order set. In DY 8, we plan to increase staff education in relation to filling out the Check List, and increasing testing/usage of the Access database by the QI Coordinator, with plans to make it a live operating system in the future. Currently, we use Excel Spreadsheets to track our data and create graphs from the results. For example, we graphed the data from our Screening Tool pilot and disseminated the results to all the DSRIP Sepsis Steering Committee members, members of Administration during presentations, as well as the units participating in our Pilot Phase. During our monthly Sepsis Committee meetings, using the PDSA (plan, do, study, act) model, we analyzed our results and discussed improvements, and then went back and implemented small tests of change. Details of this are included in the narrative for milestone 6.

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

Achievement Value   1.00

Optional Milestone: 4. Retrospectively review all Sepsis patient charts from a 6 month period in 2011 to establish baseline.
(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

This milestone was complete with our first half DY 7 report. A retrospective manual chart review to establish baseline data was completed in 2011. We abstracted data from the months of January-June 2011, and our baseline Total Resuscitation Bundle Compliance was 19%. This value represents our total % compliance with all 4 elements of the Resuscitation Bundle. Four Nurses that are members of the DSRIP Sepsis Steering Committee completed the 100% retrospective manual review, using the data monitoring criteria established in July 2011. Charts were pulled using the directions from SNI to use the 3

Category 4: Severe Sepsis Detection and Management *(required)*

using the data monitoring criteria established in July 2011. Charts were pulled using the directions from SNF to use the 3 codes from Table 1, or any combination of specific codes from Table 2 & Table 3, and then apply the exclusion criteria (listed in Milestone # 1). Data abstraction was a challenge since we are an all paper system, with the exception of lab and pharmacy data. This milestone was extremely time consuming and very labor intensive for us to accomplish. We looked at over 800 charts for this time period, and it took anywhere from 15 min-1hour per chart to review and abstract the data. Sometimes three different electronic databases had to be accessed once the manual chart review was complete to obtain all the necessary data (lab, pharmacy, etc).

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

Optional Milestone: 5. Participate in the BEACON collaborative to learn and share best practices related to improving Severe Sepsis and Septic Shock detection and management.
(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

This milestone was complete with our first half DY 7 report. We participated in the IHI and SNI Collaborative as well as attended Cynosure events (BEACON collaborative has changed). As evidenced by our DSRIP Sepsis Steering Committee minutes, Team Leads from the Sepsis Committee have participated in multiple webinars and learning sessions throughout 2011 and 2012. As a result of our increased knowledge of Sepsis and DSRIP, quality improvements have been made in both proactive care and data collection throughout this process. We gave an example of this in milestone #1: As our own education and training is enhanced through participation in the SNI Collaborative, Seminars, reading research articles, and Sepsis Committee meetings, our program is evolving. Our Chart Review Check List has been polished to be more in line with the SNI Sepsis Data Collection Flow Diagram, which help us maintain strict definitions and data integrity. In order to ensure accurate data, we have centralized data collection at the Quality Department (DSRIP team), and decreased the amount of staff performing the data abstractions. As a result of these improvements, our data timelines are more consistent and contain additional information, which gives us a more complete representation of our performance.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * Yes

   Achievement Value   1.00

Optional Milestone: 6. Develop plans for a hospital-wide Sepsis Screening Program.
(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

This milestone was complete with our first half DY 7 report. In December 2011, a subgroup (aka Task Force) of the DSRIP Sepsis Steering Committee developed a Sepsis Screening Tool and conducted a preliminary inpatient trial (TCNU, Rehab1 and Rehab2). Our plan to go forth with a larger Pilot Phase, which included several versions of a Screening Tool, was a direct result of this trial. Our new Pilot Phase ran from February-June 2012, and it involved four inpatient units (CCU, MICU, TCNU, and Rehab1) and our ED. We held many education in-services, consisting of Sepsis definitions, statistics, pathophysiology, and Resuscitation Bundle Elements (based on Early Goal Directed Therapy), over several months for both RNs and MDs that participated during this phase. We conducted regular audits of staff performance using the tools, and then provided them with feedback and encouragement. We discussed the results at our monthly Sepsis Committee meetings and used the data to make plans/protocols for the hospital-wide roll out of The SCVMC Sepsis Program, which is expected to start in August 2012. As we move forward with electronic medical records, data monitoring criteria will continue to be a challenge as we design and insert a Screening Tool, etc into the documentation. The Emergency Dept. developed a plan in 2011 for an application in WellSoft, which is their electronic medical record. Our ED is the only unit that almost exclusively documents care in an electronic medical record (EMR). As we are moving to a hospital wide EMR, expanding our WellSoft application to include a screening tool has been a challenge. Since we will no longer be using their system as of May 2013, we are not investing any money to update or enhance the capability of what we currently have. As evidenced by our Sepsis Team meeting minutes, we have had many meetings and in-services with ED Nurses, ED QI staff, and ED Information Technology staff, in order to improve accuracy of the Sepsis Screening Tool. As a result of applying the PDSA model throughout our Pilot Phase, the WellSoft screening tool has gone through several changes, and we will continue to tackle this issue moving into DY 8. The Severe Sepsis Bundle Compliance Check List (mentioned in the narrative from milestone #1) was developed in 2011 as well, to be used as both a tracking tool for data collection and a report tool for the Nurses. This Check List is to be completed for patients that screen positive for Severe Sepsis/Septic Shock who receive the 4 Elements of the Resuscitation Bundle. As previously mentioned, we have made multiple changes to all of these tools using the PDSA model since we started our expanded Pilot Phase in 2012. Evidence of change is kept in our Sepsis Committee meeting minutes and our electronic files.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * Yes

   Achievement Value   1.00

Category 4: Severe Sepsis Detection and Management *(required)*

Optional Milestone:	7. Implement the four strongest elements of the Sepsis Resuscitation Bundle for which there is the most evidence of reliability and efficacy (based on the recommendations of the Gordon and Betty Moore Foundation's Integrated Nurse Leadership Program and other sepsis prevention collaborative): as evidenced by the completion within 6 hours for patients with Severe Sepsis, Septic Shock, and/or lactate > 4 mmol/L (36 mg/dl) of the following: Serum lactate measured, blood cultures obtained prior to antibiotic administration, improve time to broad-spectrum antibiotics: within 3 hours for ED admissions and 1 hour for non-ED ICU admissions, in the event of hypotension and/or lactate > 4 mmol/L (36 mg/dl): deliver an initial minimum of 20 mL/kg of crystalloid (or colloid equivalent), apply vasopressors for hypotension not responding to initial fluid resuscitation to maintain mean arterial pressure (MAP) > 65 mm Hg. As evidenced by either a report from chart review or database

(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

This milestone was complete with our first half DY 7 report. Physician, RN, and Pharmacy education was completed for the SCVMC Sepsis Resuscitation Bundle and it remains ongoing for new employees. We continue to expand our education as we move through the Pilot Phase into our formal hospital-wide Sepsis Program. A Physician member of our Sepsis Committee developed a Sepsis Card also known as a Pocket Tool in 2011. For the first half of DY 7, more than 200 of the cards had been distributed to MD's. As of June 2012, about 700 of the cards have been produced and distributed to House Staff (MD), as well as to the Nurses in the Pilot units, and to those who have attended Sepsis Seminars where we were presenters. In 2011, the Sepsis Committee developed a Sepsis Order Set, which was approved by the Pharmacy Committee, the Critical Care Committee, and our Forms Committee. This Order Set has been available throughout our Pilot Phase. The Order Set contains all of the Early Goal Directed Therapy guidelines; however our antibiotic order form remains separate as directed by the Pharmacy Committee. The Order Set is organized into three categories (Sepsis/Severe Sepsis/Septic Shock) to outline the specific care guidelines for each of the three clinical syndromes. To further help Physicians and Nurses, the Order Set exactly matches the information that is contained on the Pocket Cards we distributed to staff. All of our inpatient units and ED have had their Pyxis (Medication dispensary) systems expanded to include broad spectrum IV anitbiotics in preparation for meeting the standard of rapid antibiotic administration. As a result of our education efforts and system improvements, SCVMC Total Bundle Compliance has had a measurable increase, and therefore our patients are receiving improved quality of care.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * Yes

Achievement Value 1.00

Category 4: Severe Sepsis Detection and Management *(required)*

Optional Milestone:	8. Report at least 6 months of data collection on Sepsis Resuscitation Bundle to SNI for purpose of establishing the baseline and setting benchmarks.

(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`

This milestone was complete with our first half DY 7 report. We reported 6 months of data collection (January-June 2011) on our compliance with the Sepsis Resuscitation Bundle to SNI for purposes of establishing baseline data and setting benchmarks. The baseline data was 111/586 (19%).

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * `Yes`

Achievement Value   `1.00`

Optional Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement

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: *

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

Achievement Value   `N/A`

Optional Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   `N/A`

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: *

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

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012
Category 4: Central Line Associated Blood Stream Infection (CLABSI) *(required)*

Below is the data reported for the DPH system.
 * Instructions for DPH systems: Please type in all of your DY milestones for the project below and report data in the indicated boxes (*).
* ☐ The yellow boxes indicate where the DPH system should input data
 ◼ The black boxes indicate Milestones and will automatically populate and flow to summary sheets
 ☐ The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically populate and flow to summary sheets

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Central Line Associated Blood Stream Infection

DY Total Computable Incentive Amount:	* $ 3,569,500.00
Incentive Funding Already Received in DY:	* $ 2,007,843.75

Compliance with Central Line Insertion Practices (CLIP) (%)

Numerator	* 669.00
Denominator	* 695.00
% Compliance	96.00

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

As reported to National Health Safety Network (NHSN), CLIP compliance for DY7 (July 2011—June 2012) was 96 % with a numerator/denominator of 669/695 (Source NHSN, accessed 9/27/12). Prior to DY7, our system to collect central line insertion practice (CLIP) data was limited and did not capture all central lines placed, despite a 96% compliance with CLIP practices as reported to NHSN. In the 1st half (H1) of DY7, the CLABSI team trialed and implemented new collection practices in the ICUs. During the 2nd half (H2) of DY7, multiple changes were made to these practices using the PDSA model, with meaningful improvements seen in both data and compliance. Despite improved data collection and management in H2 of DY7, our new methodology yielded a numerator/denominator of 387/569 and lower compliance rate of 68%, compared to the NHSN data for the same time period. Central lines placed without proof of CLIP form completion continued to be assigned 0% compliance since insertion practices could not be evaluated in those instances. NICU was excluded from the new collection practices as they previously instituted their own methodology changes based on best practice recommendations and long-standing participation with the California Perinatal Quality Care Collaborative (CPQCC). As a result, NICU was further along in their compliance improvement strategies than the other ICUs and required no similar practice changes for DY7 milestones.

DY Target (from the DPH system plan)	*
% Achievement of Target	N/A
Achievement Value	1.00

Optional Milestone:	1. Implement the Central Line Insertion Practices (CLIP), as evidenced by data reported to the NHSN via the CLIP adherence monitoring form and daily documentation of line necessity.
	(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

The CLABSI Team, which is comprised of the Director of Burn Center, an Internal Medicine Physician, Nurse Managers for the Burn Unit and Infection Prevention Department, DSRIP QI Coordinator, PICC Team RN, Vascular Access RN and Quality Management Data Analysts, meets weekly to review, assess and revise activities surrounding DSRIP milestones. DY7 activities are noted below.

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

CLIP Compliance Data

In H2 of DY7, the MS-Access database (Central Line database), implemented in the ICUs in November 2011, continued to be the primary means for collecting daily central line information; however, by January 2012, it was evident that database information did not correlate to NHSN data. We identified two contributing factors that required a significant amount of our focus in H2 of DY7:

1. NHSN Database Data: In the past, completed CLIP forms were faxed to the Infection Prevention Department (IP) for entry into NHSN with no confirmation of receipt. As a result, IP was only aware of central lines for which a CLIP form was received. In January 2012, to ensure capture of all CLIPs, the DSRIP CLABSI Team began collecting CLIP forms on a weekly basis, logging them into a secondary CLIP database, which is used as a data cross-check tool, and delivering them to IP. IP now enters CLIP data into NHSN weekly instead of monthly. NICU continues to submit CLIP forms to IP via fax.

2. Quality of Central Line Data: the Central Line database is used to collect daily central line and device days information in the adult ICUs and PICU. Using the PDSA model, the CLABSI Team instituted weekly review of the database and found ongoing entry errors. These errors resulted in an inflated number of lines (denominator) being counted, which impacted both CLIP compliance and CLABSI rates. To mitigate these errors, a superuser was selected for each unit as the point person to enter data, fix discrepancies and educate other users. Weekly data discrepancy feedback is provided to the superusers for correction and education. In April/May 2012, a new data scrub process was implemented that included using manual chart audits to remove discrepancies and ensure the correct number of unique central lines is being captured. For comparison, we used this process to perform a second data review for March 2012 and found CLIP compliance was actually at 85.5%, versus 52%, using just the Central Line database data for the same month. Despite significant improvements in data quality, the Central Line database continues to require significant monitoring with ongoing and frequent feedback to and from the users. These manual processes are expected to continue until the implementation of the facility EHR, scheduled to begin in May 2013. Members of both the CLABSI Team and the Quality Management Department are participating in HealthLink (EHR) workgroups to ensure CLIP/CLABSI data collection needs are being built into the EHR. To show appreciation and create opportunities for face-to-face feedback from the ICU staff, the CLABSI Team is frequently on the units either delivering snack treats or posting monthly compliance results. As a result, we are able to address many immediate staff concerns, troubleshoot database issues in real time and provide timely kudos to the users.

Line Necessity Documentation

Spot auditing of inpatient charts to monitor line necessity documentation began in October 2011. By January 2012, it was clear that a systematic audit procedure was needed to provide meaningful information on compliance with this bundle element. Additionally, the CLABSI Team believed these audits would be another tool to improve the quality of Central Line data. We engaged the Vascular Access Committee representatives from each ICU to audit all patients with central lines in their respective units every Wednesday. Instructions and protocols were developed and by the end of January, sufficient data was being collected to compare compliance trends by unit. After an initial improvement in overall line necessity documentation from January (58%) to March (64%) for the ICUs, compliance dropped to 60% in April. Using the PDSA model, we found that the rotation schedule of Medical and Surgical Residents plays a big part in maintaining compliance, as resident turnover is frequent and occurs at different intervals for different services. Education of Medical and Surgical Residents and Interns is provided via monthly emails, weekly lunch meetings and on an individual basis. More frequent education is needed to keep a large percentage of both the Resident and Intern pools aware of this requirement. Additionally, improved surveillance on the part of the Attendings responsible for signing off on the daily progress notes is needed. Ongoing physician education is addressed with the Attending Staff in monthly Critical Care meetings, monthly Department of Surgery meetings and on an individual basis. The CLABSI Team plans a focused effort on improving line necessity compliance in DY8 and has been participating with HealthLink work groups to build line necessity documentation into the EHR, scheduled for deployment in May 2013.

Carts

During the September 2011 SNI Learning Session, the use of Central Line Insertion Carts was identified as a beneficial means of reducing barriers to compliance as it minimized the effort in collecting supplies for insertion by reducing the steps required. In January 2012, administrative approval was received for four carts to be purchased and placed in the adult ICUs and PICU. We selected the Starsys 5-drawer rolling model with combination locks to ensure safety and ease of use. In collaboration with Central Supply and the Transport Team, supply lists and stocking protocols were developed. To augment CLABSI Team efforts, the Vascular Access Nursing Committee was engaged to educate the ICU staff regarding use and effectiveness of carts with CLIP compliance and CLABSI rates. Due to vendor-related issues, implementation was delayed until May 2012, with a trial roll out in the Burn Unit. After receiving excellent feedback from the physicians on ease of use, full roll out in the Surgical, Coronary Care, Trauma and Medical ICUs was completed in June 2012. PICU continues to use their PICC/Central Line cart. Education handouts were provided for nursing and one-page laminated instruction sheets attached atop the carts. Blank CLIP forms are available in the carts and completed CLIP forms placed in the top drawer for the CLABSI team to collect weekly. Using the PDSA model, we have identified and resolved issues

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

with certain supplies and dedicated cart staging locations for the carts when not in use. In DY8, we will focus on improving a tracking system for supplies and monitoring the impact of carts on CLIP compliance.

Education

In H2 of DY7, the CLABSI Team was involved in several education activities to improve staff knowledge of CLIP and CLABSI. In collaboration with SCVMC's Professional Development Council, we presented CLIP information at several half-day DSRIP overview classes for the general nursing staff. In May 2012, we collaborated with the Research Council to present a one-day workshop , "CLABSI, debugged", which was open to all disciplines and included information on regulatory history, financial impact, central line infections, current in-house DSRIP CLIP activities, insertion and maintenance protocols and lessons learned from successful implementation of a similar CLIP program. Positive feedback was received for these presentations and we plan to participate in similar classes in DY8. Evidence-based CLIP practices and central line management have been integrated into the general nursing orientation and annual nursing competency classes, which are attended by at least one of the CLABSI Team members. Some members of the CLABSI Team are also members of the Vascular Access Nurse (VAN) Committee, which is comprised of unit representatives from each nursing department and meets monthly to share best practices regarding vascular access and outcomes. VAN members are regularly updated on CLABSI Team activities and, in turn, act as CLIP resources for their respective units. . Medical and Surgical Residents and Interns receive education on CLIP, CLIP form documentation and CLABSI via monthly

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)*

Optional Milestone:	2. 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)   * [　　　]

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]

CLIP Compliance data, collected from 7/1/2011 to 12/31/2011, was submitted to the Safety Net Institute (SNI) for the purposes of establishing a baseline rate from which improvement could be measured. In the 2nd half of DY7, SCVMC conferred NHSN viewing rights to SNI so their staff could view and collect the required quarterly data, eliminating the need for CLIP report submissions.

We noted previously that our new collection processes, implemented in November 2011, identified a lower CLIP compliance (55%) than was being reported through NHSN (99%) for the same period. Since this decrease was evident only eight weeks into using our new methodology, we anticipated even lower compliance once an additional six months of data was collected. In April 2012, SNI requested that we set an improvement target for CLIP compliance to be achieved by June 2013. Based on our new methodology, compliance for January, February and March 2012 was 58.3%, 56.4% and 52%, respectively, making our cumulative CLIP adherence 55.6% for 2012Q1. This was concerning to the CLABSI Team as NHSN bundle compliance for 2012Q1 was 98%, with a numerator/denominator of 220/224, as confirmed by SNI. Due to this large disparity between data sources and the significant work we anticipated to improve our data processes, we set our compliance improvement target at 75%, believing it was an ambitious goal for the purposes of the SNI Sepsis/CLABSI Collaborative. We implemented a new scrub process in May 2012 and re-scrubbed March 2012 data for comparison. We were able to show a 33.3% higher compliance at 85.5% for March over what our pre-scrub data showed and 10.5% over our improvement target for SNI. Continuing with the new scrub process, in 2012Q2, we determined our overall internal CLIP adherence rate to be 89.6% (189/211), compared to 91% (189/207) as reported to NHSN for the same period (Source: NHSN, accessed 9/27/12). The CLABSI Team continues to use the PDSA cycle to identify and mitigate errors with CLIP compliance data. Additionally, we regularly participate in SNI collaborative offerings, which provide frequent opportunities for networking and shared learning.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [Yes]

  Achievement Value   [1.00]

Optional Milestone:	3. Report at least 6 months of data collection on CLABSI 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)   * [　　　]

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]

CLABSI data, collected from 4/1/11 to 9/30/11, was submitted to SNI on December 15, 2011 for the purposes of establishing a baseline rate from which improvement could be measured. For that period, we found a numerator/denominator of 3/8181 for an aggregate CLABSI rate of 0.37 (Source: NHSN, accessed 12/14/11). This was noted to be the lowest CLABSI rate amongst all the facilities participating in the SNI Sepsis/CLABSI Collaborative. Early in 2012, SCVMC conferred NHSN viewing rights to SNI so their staff could view and collect the required quarterly data, eliminating the need for CLABSI report submissions. During H2 of DY7, we continued our efforts with CLABSI education and worked to improve the reliability of denominator data (see milestone 2). Numerator data continued to be collected by IP per department protocol.

For DY7, our 12-month aggregate CLABSI rate was 0.26%, with 4 CLABSIs in 15573 central line days (Source: NHSN, accessed 9/27/12). We reported our quarterly CLABSI rates to SNI as follows:

Baseline data April-September 2011: 0.3666%. 3 CLABSIs in 8184 central line days. (Source: NHSN, accessed 12/29/11. Receipt confirmed by SNI on 1/3/12)

2011Q4: 0.26%. 1 CLABSI in 3882 central line days. (Source: NHSN, accessed 9/27/12. Conferred NHSN viewing rights to SNI in 2012Q1, prior to 3/31/12 submission deadline)

2012Q1: 0%. 0 CLABSIs in 3935 central line days. (Source: NHSN, accessed 6/29/12. Confirmed by SNI on 7/11/12)

2012Q2: 0.26%. 1 CLABSI in 3809 central line days. (Source: NHSN, accessed 9/27/12. Pending confirmation by SNI)

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

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

Optional Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*
Denominator (if absolute number, enter "1")	*
Achievement	

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: *

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

DSRIP Semi-Annual Reporting Form

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

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [____]

Denominator (if absolute number, enter "1")   * [____]

   Achievement   [N/A]

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: * [____]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [____]

   Achievement Value   [____]

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [____]

Denominator (if absolute number, enter "1")   * [____]

   Achievement   [N/A]

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: * [____]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [____]

   Achievement Value   [____]

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [____]

Denominator (if absolute number, enter "1")   * [____]

   Achievement   [N/A]

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: * [____]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [____]

   Achievement Value   [____]

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

Optional Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

Optional Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

Achievement Value   [   ]

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

Category 4: Surgical Site Infection Prevention

REPORTING ON THIS PROJECT: * | Yes |

Below is the data reported for the DPH system.
 * *Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',*
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).
 *   The yellow boxes indicate where the DPH system should input data
      The black boxes indicate Milestones and will automatically populate and flow to summary sheets
      The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
      populate and flow to summary sheets

Surgical Site Infection Prevention

DY Total Computable Incentive Amount: * | $ 3,569,500.00 |

Incentive Funding Already Received in DY: * | $ 2,498,650.00 |

Rate of surgical site infection for Class 1 and 2 wounds (%)

Numerator   * | |

Denominator   * | |

   % Infection Rate | N/A |

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

At the time SCVMC's DSRIP plan was written, a disparity existed in the number of surgical procedures on which the State required facilities to report, ranging between 2 and 29. With clarification pending from the State, the DSRIP Surgical Care Improvement Project (SCIP) Committee initially opted to select all 29 of the procedures for SSI monitoring through the Waiver Program. Subsequent to the State's ruling that, for the purposes of the DSRIP Program, fewer procedures were to be monitored, SCVMC limited its SSI focus to three areas: (1) Colon surgeries, selected for inconsistencies identified in compliance with SCIP measures, despite a low infection rate at 1.96, (2) Laminectomies, selected for high infection rate at 5.45, and (3) Coronary Artery Bypass Grafts (CABG), selected in spite of a low (absent) infection rate, for compliance issues identified with postoperative blood glucose control, a known risk factor for SSI in this setting . Additionally, each of these procedures is on the priority list of procedures identified by the HAI Advisory Committee to the California Department of Public Health .

Rate of Surgical Site Infection in DY7

Per our DSRIP Plan, approved by CMS and DHCS, we will be reporting our rate of surgical site infection (SSI) for class 1 and 2 wounds in Demonstration Year (DY) 8 to both the State and SNI. SCVMC has conferred viewing rights of our SSI data in the National Healthcare Safety Network (NHSN) database to SNI so that they may access our SSI information at their discretion for review or comparative purposes.

NHSN Data Upload

Lack of data personnel within the Infection Prevention Department led to utilization issues that caused delays or deficiencies in data uploads to NHSN. The process was labor intensive and resulted in data that required review and modification to ensure accuracy and maximal capture of qualified surgical cases. A conversion program was developed in the 1st half of DY7 (July – December 2011), which greatly reduced the manual entry workload but created problems with discrepancies in the data. In the 2nd half of DY7 (January – June 2012), a collaborative workgroup, consisting of the Chief of General Surgery, Infection Prevention Nurse Manager, the DSRIP SCIP Committee and staff from Perioperative Services, Infection Prevention, Quality Management and Pharmacy was convened to troubleshoot the process. Problems with formatting and terminology in surgical and trauma data were identified and addressed, with an emphasis placed on streamlining the process and eliminating the need for paper chart pulls by optimizing the use of our available electronic patient information sources. The raw data sets from our computer system in the OR computer system and Trauma data registries are now entered into an MS-Access program, developed through SCVMC's Information Services Department and implemented in December 2011. This program converts the data to an upload format acceptable to NHSN web-based reporting software. The program identifies files that require review and sources of the additional data. This data and the verification required to reconcile inconsistencies occur directly through our electronic record system (ClinWeb) resulting in a streamlined process to "scrub" and prepare data for uploading. Monthly data scrubs have been instituted to ensure clean data is available for prompt upload on an ongoing basis. This work, initially thought to require the addition of a full FTE, has now become fully manageable with our existing staff. Initially, all data for cesarean sections performed in the Labor and Delivery Suites had to be handled separately and manually, due to incompatibilities between their newly acquired electronic system (Centricity) and the hospital systems that were already in place. In the 2nd half of DY7, the DSRIP SCIP Committee assisted in the process of creating an obstetric conversion program used to input and upload cesarean data into NHSN. Troubleshooting and process needs for the obstetric program will be addressed in DY8. It is anticipated these programs will remain in use until SCVMC implements its new system wide electronic health record, scheduled to begin deployment in mid-2013.

1. Data Source: NHSN Database, accessed 12/22/11.
2. California HAI Advisory Committee, SB 1058 SSI Reporting Requirements Discussion, February 8, 2011,

DY Target (from the DPH system plan)   * | |

Category 4: Surgical Site Infection Prevention

% Achievement of Target	N/A
Achievement Value	N/A

Optional Milestone:	1. Develop SCIP based preprinted order sets and update all existing preprinted surgical core sets to reflect current SCIP guidelines.
	(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

This milestone was fully achieved in the first half (H1) of DY7. DSRIP SCIP focus in the second half (H2) of DY7 was placed on reviewing and revising surgical pre- and post-operative SCIP order supplemental sets as needed to be consistent with the guidelines as defined by the University Health Consortium (UHC). To date, post-operative SCIP order sets are included in OR packets for all inpatient surgical cases and preoperatively for patients scheduled for surgery. The SCIP guidelines have been integrated into the Cardiac Surgery post operative order set and the Obstetrics and Gynecology post operative order sets. The Colon Surgery and Cholecystectomy post operative order sets for the General Surgery Service are under revision at this time and are pending and are on track to be updated by 2013, in compliance with hospital policy. Neurosurgery, which impacts one of our targeted procedures (Laminectomy), has an ICU admission order set but not a standard post operative order set. Neurosurgery order revisions are in the queue; however, since other services were further along in the process, they were chosen for modification first.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * Yes

Achievement Value   1.00

DSRIP Semi-Annual Reporting Form

Category 4: Surgical Site Infection Prevention

Optional Milestone: 2. Develop a process where the proper preprinted order set is included in the preoperative packet to improve compliance.

(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

Development of pre- and post-operative surgical order supplemental sets was completed in the first half of DY7; however, placement of pre-operative SCIP orders in the pre-operative packets did not begin until January 2012. Completed order sets were provided to the Ambulatory and Community Health Services (ACHS) staff to include in preoperative packets for scheduled surgery patients. Nursing in-services regarding the nurse's role in completing the order sets were completed in January 2012 for Operating Room (OR) and Post Anesthesia Care Unit (PACU) staff. Information was provided to the Managers of the Surgical floors, Pediatric units, and Surgical and Trauma ICUs. Ongoing physician education has been implemented and story boards have been placed in the OR Doctor's Lounge as reminders. In March 2012, the use of SCIP orders was started for all postoperative patients, with the exception of outpatients and those under the age of 18. In April 2012, prospective spot auditing of surgical charts revealed good compliance at 80% (4 out of 5 charts in Surgical ICU) with use of postoperative SCIP orders in both the General Surgery and Cardiovascular Services. Once a week retrospective auditing of charts for all surgical services began in May 2012, revealing a much lower compliance at 17% (12 out of 69 charts) overall. Using the PDSA model, we found that the orders as a separate module were at times misfiled into the Operative Procedure section of the chart rather than the Physician Order section, resulting in confusion as to proper use by both nursing and physician staff. Although we initially felt that implementing SCIP orders as a separate module would result in a more rapid rollout, the compliance data indicated a greater need to accelerate the modification of all service-specific post operative order sets to include SCIP compliant orders, intended to maximize full utilization and consistency throughout the system. To date, Cardiac Surgery order sets have been revised to include all SCIP measures, including the modifications to the Insulin drip protocol that was identified as problematic in our last report. Due to recent UHC-recommended changes to prophylactic antibiotic guidelines, the Obstetrics and Gynecology services were advised to implement full SCIP revision of their post operative order sets in conjunction with the changes. General Surgical post operative order sets for Colon Surgery and Cholecystectomy are currently under revision. Since Laminectomies are one of our targeted procedures for SSI, post operative order sets for the department of Neurosurgery were considered as a priority for full integration of SCIP measures. However, the Neurosurgery service had developed only a preprinted ICU admission order set in the past and has no specific post operative order sets. A collaborative group including Pharmacy, the DSRIP SCIP team members, Surgical Critical Care nursing and physicians, and Neurosurgery will meet to develop this order set in DY8. As our system-wide Electronic Health Record (EHR) begins roll-out in May 2013, the Computerized Physician Order Entry (CPOE) will be included in the first wave of implementation. The development of preprinted service specific SCIP compliant orders at this time will facilitate the workgroups that are implementing that portion of the EHR in preparation for our go-live date in May 2013. The remaining surgical subspecialties will follow. In the interim, education to increase awareness of SCIP measures and SSI is ongoing with both the nursing and medical staff.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * Yes

Achievement Value   1.00

Optional Milestone: 3. Continue with educational models for attending staff, house staff, perioperative staff and medical/surgical unit nursing on current evidence based SCIP guidelines

(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

In January 2012, education with OR and PACU staff included correct documentation of: (1) anesthesia end time, defined as "wheels out the OR door", and (2) wound classification information, after verification with the surgeon. SCIP Wound classification charts and antibiotic dosing schedules have been placed in each OR Suite. In April 2012, comprehensive surgical Checklist was developed and approved in May 2012 by the OR Committee and Medical Executive Committee and Nursing leadership within the OR. To increase compliance with SCIP measures, this Check list includes verification of proper administration and documentation of pre operative prophylactic antibiotics, use of DVT prophylaxis and beta blockade when appropriate, and accurate recording of procedure name and wound classification at the close of the

case in addition to the other safety guidelines recommended by the Joint Commission (TJC) and World Health Organization (WHO).

The educational activities surrounding SCIP have resulted in improvements in our reported scores, in spite low utilization of the SCIP order module, as evidenced in our first quarter 2012 report on SCIP compliance. We were at or above state

Category 4: Surgical Site Infection Prevention

and national benchmarks for all but two measures: 1) discontinuing the prophylactic antibiotics within 24/48 hours end anesthesia time and 2) cardiac surgery patients with controlled 6 AM blood glucose levels. A case-by-case review of the outliers was performed and outliers were discussed in the Cardiovascular and Orthopedics departments. As a part of the Ongoing Professional Practice Evaluation (OPPE) within the Department of Surgery, the results in this Core Measure data from UHC are reviewed with individual physicians in their aggregate form and each case attributable to them as individuals is also reviewed. The serum glucose control is thought to be a Critical Care provider sensitive measure and in the most recent OPPE cycle our attribution model allowed us to review outlier cases with the Critical Care provider involved as well as the Performing Surgeon. In DY8, we are scheduled to roll out a computerized system that will streamline the process of identifying SCIP outliers which should facilitate this process. We continue to address SCIP compliance on daily teaching rounds and in the regularly scheduled (weekly) Morbidity and Mortality conferences. Compliance with SCIP/DSRIP and other regulatory measures was addressed by the Medical Staff President at orientation for new attending staff in April 2012 and in June 2012 for the incoming interns and residents at both SCVMC for our own residents and at Stanford for the Surgery and Emergency Medicine residents that provide care in this facility on a rotating basis.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * Yes

   Achievement Value   1.00

Optional Milestone: 4. Implement quality checklists on the formatted inpatient notes
                                      (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

Discussions with the CEO and head of the Forms Committee over the issue of the need for approval of daily note templates resulted in an exemption from the standard (and lengthy) review process for these documents. The arguments for exemption included the rapidity with which there are changes in the documentation requirements for billing and coding requirements as well as quality and regulatory medical documentation standards, and the number of service notes that would require immediate approval. Minimum standards for demographic patient information and pagination and identification of the hospital on each page were agreed upon, in compliance with hospital policy and Health Information Management (HIM) standards, and modifications could be made in the body of the note as needed. As soon as the exemption was clarified, the Quality Checklists on the daily notes for General Surgery and Surgical Critical Care were updated and/or revised to include the mapping information for SCIP requirements and other pertinent DSRIP quality/safety measure data, in order to centralize documentation for DSRIP measures and increase awareness of daily documentation requirements. This mapping plays a critical role in the ongoing educational process for residents in training who are contributing to the documentation in the chart but who also must understand the principles underlying documentation standards in the legal medical record. The Burn Unit, run by Plastic Surgery Service, requested and was sent an electronic copy of the Quality Checklist after revision in order to integrate it into their daily note. Neurosurgery also has been sent the template note to include the Quality Checklist in their note. Cardiovascular surgery patients are now all co-followed in the initial post operative period by Surgical Critical Care so duplication of this on their ICU documentation was not needed. We have addressed the issue of Quality Checklist on their ward documentation but are focusing on rolling the Quality Checklist out to services that have a computerized note already developed to maximize our efforts. The additional benefit of the daily Quality Checklist is how it works to facilitate auditing for DSRIP reporting until we transition to an Electronic Health Record (EHR). This is not slated to occur until late in DY8 (May 2013). Orthopedics, and the other surgical subspecialties that provide primary inpatient care, will follow the implementation in Cardiovascular Surgery and Neurosurgery. The priorities were set in this order due to the focus procedures chosen for SSI monitoring in the previous DY7. Outpatient subspecialties such as Podiatry and Ophthalmology will be excluded as they do not have admitting

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * Yes

   Achievement Value   1.00

Category 4: Surgical Site Infection Prevention

Optional Milestone: 5. Continue to measure and report compliance with SCIP process measures
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

Achievement   N/A

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: *

Process and outcome measures continue to be monitored and reported by the Improvement Department in accordance with Surgical Care Improvement (SCIP) guidelines. Compliance data on SCIP process measures continues to be reported quarterly to United Health Care-CMS. Despite notable improvements with SCIP measures between Q1 and Q2 of 2011, facility compliance remained below State and National benchmarks in 6 of the 10 SCIP measures. Two areas the DSRIP SCIP Committee targeted for improvement include: (1) control of postoperative blood glucose and (2) adherence to postoperative antibiotics schedule.

Glycemic Control Compliance

In 2011 Q2, compliance with SCIP Measure: Cardiac Surgery Patients with Controlled 6:00a.m. Postoperative Blood Glucose, was below State and National benchmarks at 81%. An ad hoc glycemic control committee was established in February 2012 to address Insulin protocols as a means of controlling postoperative glucose levels and their impact on SSIs. The committee includes representatives from Cardiothoracic Surgery, General Surgery, Endocrinology, Pharmacy, Surgical/Trauma ICUs, Nursing Education and the Surgical Site Infection Committee. Manual chart review of all SCIP measure outliers was completed by the Endocrinologist. Process issues and equipment limitations were identified, prompting minor revisions in postoperative Insulin protocol. Overall the protocol used is a proven protocol that has ample evidence for efficacy and literature support in cardiovascular patients in particular. Initial Endocrinology review/revision of glucose management orders was focused on Cardiovascular surgery patients but was expanded to encompass all ICU patients. In standardizing the insulin drip protocol for all ICU patient (both medical and surgical), it was felt that there would be improved familiarity and better implementation across the institution. Initial nursing education with feedback has been completed. Revised Insulin orders have been approved by the Forms Committee, Critical Care Committee, as well as Pharmacy and Therapeutics Committee and implemented in both the Cardiovascular Surgery specific post operative orders and the generalized ICU insulin drip order sets. Compliance with these orders has been reviewed during staff meetings and compliance results posted in the respective units. This should be reflected in the SCIP Core Measure Data in the upcoming reporting periods. We will continue to monitor this and review all outliers with this important outcome measure with the involved providers and nursing as needed.

Post-operative Antibiotic Compliance

In June 2012, Pharmacy initiated discussions with the DSRIP team about improving compliance with the SCIP measure: Prophylactic Antibiotics Discontinued within 24 Hours after Surgery End Time. Pharmacy will use anesthesia end time as required by UHC standards, to start the clock for antibiotic dosing orders. This documentation piece is part of the SCIP order set modules to facilitate communication of this timepoint across the continuum of care as the patient transitions from OR to PACU to ICU or Med /Surg nursing unit. Compliance with utilization of SCIP order set modules, although important, is not sufficient for success with this core measure. We have recognized the importance in nursing and pharmacy with this measure as our case-by-case analysis indicated that there were instances where the order was written properly, but the timing of doses was off by at times as little as 30 minutes with the last dose resulting in reporting non-compliance. In conjunction with Pharmacy, Quality Management and Nursing Education staff, the DSRIP SCIP Committee will explore options for quality improvement in DY8. We will continue to monitor this and review all outliers with the involved providers

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * Yes

Achievement Value   1.00

Optional Milestone:
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

Achievement   N/A

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: *

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

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012
Category 4: Hospital-Acquired Pressure Ulcer Prevention

REPORTING ON THIS PROJECT: * | Yes |

Below is the data reported for the DPH system.
 * Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).
* ☐ The yellow boxes indicate where the DPH system should input data
☐ The black boxes indicate Milestones and will automatically populate and flow to summary sheets
☐ The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
 populate and flow to summary sheets

Hospital-Acquired Pressure Ulcer Prevention

DY Total Computable Incentive Amount:	* $ 3,569,500.00
Incentive Funding Already Received in DY:	* $ 3,049,245.38

Prevalence of Stage II, III, IV or unstageable pressure ulcers (%)

Numerator	* 9.00
Denominator	* 882.00
Prevalence (%)	0.01

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

Our annual prevalence rate is 1% for DY7 which is lower than the set rate of 1.75% for DY8. We had only 9 HAPUs in a total of 882 surveyed patients. This high performance is a result of close collaboration between the nurses and physicians to prevent HAPUs at the facility. This rate is based on the Collaborative Alliance for Nursing Outcomes (CALNOC) methodology, which is a point in time measurement. The purpose of prevalence quality study is to provide a "snapshot" of pressure ulcer within a specified population on a selected day in a quarter. All patients who are present at the time the pressure ulcer quality study is conducted are included in the data collection. There are 12 SCVMC inpatient units participating in this survey: 1Rehab, 2Rehab, 3Surg, 4Med, 4Surg, Transitional Care & Neuro Unit (TCNU), Surgical ICU, Trauma ICU, Rehab Trauma Care (RTC2), Medical ICU, Coronary Care Unit and the Burn Center. The following patients are excluded from the survey: Patients who are medically unstable at the time of the prevalence quality study for whom assessment would be contraindicated, patients who are terminal and pressure ulcer prevention is no longer a treatment goal, patients not on the unit during pressure ulcer prevalence study, and patients who refuse to be examined for the presence of pressure ulcer.

Santa Clara Valley Medical Center's Hospital Acquired Pressure Ulcer (HAPU) Program

Skin and wound care is an integral part of the patients' hospital experience at Santa Clara Valley Medical Center (SCVMC) and requires a multidisciplinary collaborative team approach. The interdisciplinary team consists of nursing staff, physicians, wound and skin care specialist, dietician, clinical pharmacist, and occupational and physical therapist. Based on existing standards, patients can expect to have their skin integrity assessed on admission and at clearly defined intervals with an appropriate skin integrity treatment plan. The "Braden Scale for Predicting Pressure Ulcer Risk" is used to identify patients at risk of developing a pressure ulcer. Our approach for preventing pressure ulcers and skin breakdown is based upon evidence-based practices, products, equipment, and screening tools.

We are preventing pressure ulcer incidence by focusing on the following coordinated strategic elements for our inpatient population:

- Prompt assessment and treatment
- Appropriate pressure ulcer assessment and monitoring tools
- Steps to monitor treatment effectiveness
- Pressure ulcer treatment techniques that are consistent with clinically-based guidelines

Staff received education on pressure ulcer staging and on effective auditing of patient charts for specific elements. The Wound, Ostomy & Continence Nurse Specialist presents ongoing education to clinical staff members. Physician, nurses and ancillary staff members received education on elements of wound staging, specialty bed selection, care management, and best practices.

One of the tools adopted by SCVMC is the High Risk Skin Condition Tracking Tool (HRSCT). This tool has all the key elements for identifying high risk skin condition. It identifies the pressure ulcers as Hospital Acquired Pressure Ulcer (HAPU) or Community Acquired Pressure Ulcer (CAPU). It also scores the patient according to the Braden Scale at admission until patients are deemed no longer at risk. Photography of the skin condition is done on admission, periodically, and on

Category 4: Hospital-Acquired Pressure Ulcer Prevention

transfer.

Another best practice tool is the "Turn Every Two Hours Form" aka "Turn Log." This tool is used as a reminder to turn patients at least every two hours, and as a tool to assess skin integrity. The Turn Log is used to organize care of patients who are at risk for pressure ulcers. This is a log that can be updated based on patient physical condition.

Skin care plans are initiated on all identified patients and advanced according to level of risk.
Staff is given a quick pocket reference card containing the Braden Scale on one side and the color-coded "Intervention Guide" on the reverse. The Braden Scale is also posted on bulletin boards in the nursing units.

Crucial to pressure ulcer prevention has been the creation of our Skin Care Committee, Skin Care Team Champions and the skin care rounds. The team conducts daily rounds on high-risk patients and one of the functions of the team rounds is to determine if pressure ulcers are appropriately staged and treated.

Results of quality reports are posted on staff bulletin boards, shared in Skin Care Committee, and staff meetings. Performance reports are used regularly for decision making by the entire team.

Pressure ulcers in our facility are tracked daily and reported on a weekly and monthly basis. This report comes from the Patient Safety Net (PSN) or incident reporting. A quarterly survey is used to track and trend pressure ulcer prevalence and detect any increase in pressure ulcer rates that may relate to a particular systems issue, such as lack of available equipment or decreased personnel in a certain unit. Results of these studies help to focus efforts on a particular unit, especially if a unit has a higher pressure ulcer occurrence than others. Conversely, if one unit has a lower rate, it will be used as a model for best practice to determine what is being done well, and implement those strategies on other units.

SCVMC uses Plan, Do, Study, and Act (PDSA) performance improvement model. PDSA change cycle model was used to identify the best methods for our organization as it relates to the various best practice tools the facility adopted to improve pressure ulcer care and management. Details of the PDSA cycle will be thoroughly discussed later in milestone number 13 – PDSA

DY Target (from the DPH system plan)	*
% Achievement of Target	N/A
Achievement Value	1.00

Optional Milestone: 1. Collect data: Process measures
(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

Achievements

• Assignment of an analyst to help with pressure ulcer reporting and tracking
• Data collection tools were revised in March 2012 through PDSA cycling
• Staff members were educated on HAPU prevention, care, and management
  (please see milestone #8 for educational classes conducted in DY7)

Challenges

• The forms were not filled out the same way
• Inadequate data collection training for some staff members
• Data were difficult to evaluate without additional clarification
• Preparing for seamless transition from paper to electronic documentation

The forms were revised in March 2012 to make them clear and user-friendly. Instructions on how to fill out the forms were also made clear. The staff was trained on how to fill out the forms. Standardization of reporting and tracking tools in electronic documentation is planned with the implementation of HealthLink (EHR). More detailed discussion on what forms were revised is included in milestone #13 – PDSA.

Future Plans

• Continue to evaluate compliance
• Refine the forms, if necessary, to maximize staff ease of use
• Standardize the use of forms
• Integrate pressure ulcer documentation requirements using EHR

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: 2. Collect data: Patient outcomes

(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`

Achievements

• Collected data for patient outcomes. Prevalence surveys were conducted and reported quarterly during DY7.
  Surveys were done on the following dates: Aug 10, 2011, Nov 2, 2011, Feb 1, 2012 and May 2, 2012. The annual
  prevalence rate for DY7 was 1%. We had only 9 HAPUs in a total of 882 surveyed patients. This rate is below the set
  rate of 1.75% for DY8. Both the nursing and medical staff are closely working together to prevent HAPUs at the
  facility.

To continue this high performance, the team decided to:

1. Take a closer look and investigate all HAPU incidents during the prevalence surveys, if there is any
2. Discuss HAPUs with managers and unit staff members, if any. Identify process improvement opportunities and
   develop action plans to reduce hospital acquired pressure ulcers in the future
3. Skin care champions will continue to monitor skin integrity and provide HAPU prevention education to the nursing staff
   in their respective units
4. Repeat prevalence surveys will be done in the next two months by units with HAPU cases

• Required quarterly surveys were conducted in all thirteen required units: 1Rehab- Spinal Cord Injury, 2Rehab – Head
  Injury, Rehab Trauma Care, 3Surg, 4Med, 4Surg, Trauma ICU, Medical ICU, Coronary Care Unit, Transitional Care &
  Neuro Unit, Pediatrics, Pedi ICU, Burn Center

• The HAPU QI Coordinator position was filled in May 2012

• Literature research for best practices was conducted. The committee reported their findings in March 2011. The best
  practice tools were implemented in August 2011 and revised in March 2012 using the PDSA model. The committee
  decided to consider the following tools as a result of the literature searches:

1. High Risk Skin Condition Tracking Form
2. Photo Form
3. Turn Log & Turn Clock
4. Revision of the Admission Sheet to provide area for the daily documentation of Braden Score and more extensive
   skin care assessment.

Challenges

 Continuing challenge of electronic documentation

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

   Achievement Value   `1.00`

Optional Milestone: 3. Examine HAPU versus ulcers occurring prior to admission and wound healing or
progression

(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`

Achievements

• 100% of our patients have their skin assessed for risk on admission and every shift thereafter
• Wound healing and signs of progression are assessed everyday
• Risk assessment tools were revised to capture and better monitor pressure ulcers
• Patient Safety Net (PSN) incident reporting are completed on patients with skin integrity conditions

Challenges

Category 4: Hospital-Acquired Pressure Ulcer Prevention

Challenges

• Skin care forms take a long time to revise and to become an official part of the patients' charts.

Future Plans

• Provide updated education on the new documentation requirements

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

Optional Milestone: 4. Implement best practice via evidence-based practice.

(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

Our HAPU prevention management is tethered on evidence based practices. We have a comprehensive team approach to pressure ulcer prevention and management, including leadership support, empowered nurses to order and apply appropriate pressure redistribution items, use of the Braden Scale, photo form, turn log and clock, staff training, and accountability. As a result of multiple literature searches, the following actions were taken:

• PDSA cycle was used to review the following tools:
     - High Risk Skin Condition Tracking Form
     - Photo Form
     - Turn Log & Turn Clock
• Revision of the Admission Sheet to provide area for the daily documentation of Braden Score and
   more extensive skin care assessment.
• Pressure Ulcer Quick Reference Tool – it is a colored one page information on pressure ulcer
   stages including unstageable and deep tissue injury, description of the various stages including
   photographs, recommended interventions, and names and photos of the various products for each
   stage.

The adoption of above tools empowered the nurses to be more proactive about their patients' skin care condition and to improve pressure ulcer management.

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: 5. Physician education on elements, wound staging, specialty bed selection, care management and best practices.

(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]

We have a tiered approach to addressing HAPU education. Our collaborative approach includes regular Department of Medicine staff meetings and one to one instruction provided as needed.

A skin care physician champion was appointed in May 2011. The staff physicians received education on pressure ulcer staging and specific elements of patient documentation. The Certified Wound, Ostomy and Continence Nurse (CWOCN) continues to be available to provide ongoing education to the medical staff. Physician, nurses and ancillary staff members received education on specialty bed selection, care management and best practices. This information is posted on educational bulletin boards in the nursing units. Pressure ulcer care and management continued to be a regular agenda item in the Department of Medicine staff meetings. The physician champion coordinates, attends and often presents at the following medical staff meetings:

  Monthly Department of Medicine meetings
  3x a year Surgery Department meetings
  Annual Pediatrics meeting

The following educational sessions were conducted during DY7:

1. August 15, 2011 – Pressure Ulcers Staging and Best Practices, Department of Medicine
2. December 2011 – HAPU, New Documentation Form, Department of Medicine
3. January 2012 – HAPU, Documentation Form, Department of Medicine
4. February 2012 – HAPU, DSRIP – Health Care Associated Pressure Ulcers, Department of Medicine
5. March 6, 2012 – Hospital Acquired Pressure Ulcer, Department of Pediatrics

Challenges

Our challenge is to standardize HAPU curricula and expand participation of all groups.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [Yes]

Achievement Value [1.00]

Optional Milestone: 6. Reinforce use of "Turn Log".

(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]

The "Turn Clock" together with the "Turn Log" is a standardized tool used on the nursing units. The "Turn Clock" is now permanently printed on white boards inside the patients' rooms in the Med-Surg areas. The Critical Care and Rehab Divisions continue to document their patient turns on the flowsheets. Discussions of appropriate use and compliance of "Turn-Log" and "Turn Clock" continue to be part of nursing staff meetings and Quality Improvement (QI) programs.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [Yes]

Achievement Value [1.00]

Optional Milestone: Optional Milestone: 7. Add management oversight to the Skin Care Team. Ensure every adult unit has a "Champion",

(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]

Category 4: Hospital-Acquired Pressure Ulcer Prevention

An established HAPU Team continues to ensure compliance with pressure ulcer care and management in the facility. It is composed of:

1. Chief Nursing Officer
2. Director, Nursing Professional Practice
3. Nurse Manager - HAPU Champion
4. Certified Wound, Ostomy & Continence Nurse
5. HAPU QI Coordinator, DSRIP
6. Physician Champion

We also have another committee called Skin Care Committee which includes the HAPU Team members plus SCCs from 20 inpatient units. The SCCs' role is to learn and disseminate information to their units. They also serve as resource persons for pressure ulcer care and management concerns.

The committee meets every month except during the four quarterly prevalence survey months in a year.   The committee decided to conduct the prevalence surveys during those four days in-lieu of meetings.

Achievements

• Added management oversight to the Skin Care Team
• Added a HAPU QI Coordinator as committee member
• Continued involvement of skin care champions from twenty participating units. The units with skin
  care champions are the following:

1Rehab- Spinal Cord Injury, 2Rehab – Head Injury, Rehab Trauma Care, 3Surg, 4Med, Medical Short Stay Unit (MSSU), 4Surg, Surgical ICU, Trauma ICU, Medical ICU, Coronary Care Unit, Transitional Care & Neuro Unit, Pedi, Pedi ICU, Maternity & Infant Care Center, Labor & Delivery, ED, Burn Center, Barbara Aarons Pavillon (BAP – Behavioral Health), and Emergency Psychiatric Services.

Challenges

• Addressing the challenge of allowing nurses to attend learning opportunities to enhance patient safety

Future Plans

• Continue to empower the skin care champions to be the unit experts and oversee the pressure ulcer process improvements in their respective areas

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

Achievement Value   1.00

Category 4: Hospital-Acquired Pressure Ulcer Prevention

Optional Milestone: 8. Institute education rounds by Skin Care Team Champions

(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

Our plan is to institute ongoing skin care educational rounds in all inpatient units. The SCCs have been identified and attended extensive educational classes. Currently, the SCCs are utilized as unit experts and act as unit "consultants" for skin care issues. Weekly educational rounds by the wound care nurse have been in place and are continuing on a weekly basis. Our plan is to reassemble the SCCs to develop a manageable plan for more frequent rounds.

The following are the educational classes conducted in DY7. Other training classes listed (see below) included HAPU in their agenda.

1.) Weekly Rounds by CWOCN on HAPU Prevention
     June 11-15, 2012 - 2RTC, 3Surg
     June 18-22, 2012 - 4Med, CCU, TCNU, MICU, SICU
     June 25-30, 2012 - 4Surg, MSSU, 3Surg, MICU, 2RHB

2.) Skin Champion Class by CWOCN attended by skin care champions – Jun 14, 2011
     Skin Champion Class by CWOCN attended by Assistant Nurse Mgrs - Aug 24, 2011
     Skin Champion Class by CWOCN attended by Assistant Nurse Mgrs - Aug 25, 2011

3.) "Why Give A Rip About DSRIP?" by Professional Development Council attended by hospital staff members:
     October 11, 2011
     November 1, 2011
     May 29, 2012
     August 21, 2012

4.) Hospital Service Assistant (HSA) Training Day by CWOCN attended by HSAs on HAPU Prevention
     Jan 26, 2012
     Jan 31, 2012

5.) Continuing Education Class by CWOCN attended by nurses – May 11, 2012
     May 7, 2012
     Apr 17, 2012
     Apr 20, 2012
     Apr 27, 2012

6.) Med-Surg RN Competency Days by CWOCN
     Mar 26, 2012
     Mar 27, 2012
     Mar 29, 2012
     Apr 9, 2012
     Apr 11, 2012
     Apr 23, 2012

7.) Pressure Ulcer Documentation, Webinar by National Pressure Ulcer Advisory Panel (NPUAP)
     Attended by CWOCN, HAPU Coordinator & Quality Staff on July 19, 2012

8.) Vendor-related in-service and presentations:

a. Mepilex Border Sacrum Foam Dressing – The Self Adherent Foam Dressing with Safetac
    Technology; in-service conducted by Molnlycke representative:
    March 27, 2012 – inpatient units
    March 29, 2012 – inpatient units
    March 27 – 29, 2012 – inpatient units

b. New Bari Rehab Platform Bed – bed alarm, scale and Big-Turn lateral rotation mattress features
    in-service conducted by Size-Wise Co. representative:
    August 28, 2012; 10am – 1pm, 7-10pm In-Service – inpatient units
    August 29, 2012; 10am - 1pm, 7-10pm In-Service – inpatient units
    August 30, 2012; 3-6am In-Service – inpatient units

Challenges: Regular rounds by the skin care champions continue to be a challenge due to staff shortage and restrictions on overtime and "non-productive time." Skin care champions, nurse managers, and nursing leadership are continuing discussions to develop a more manageable plan for rounds.

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: 9. Share results of data baseline with staff

(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 |

Prevalence study data are discussed quarterly with the SCCs in the skin care meetings. HAPU case studies are presented and vendors are invited to present and talk about their products. This fosters shared learning and provides support for all the skin care champions. The skin care champions share these data with the rest of the staff. The prevalence study data, related performance improvement and outcomes measures are included in each unit's Quality Program and captured in the nursing units' quarterly Quality Reports. HAPU prevalence results are shared monthly at the Hospital Quality Leadership meetings.

Results of the prevalence studies on SCVMC's pressure ulcer performance were shared in the facility's publication, Valley Nurse, in the April 2012 issue. The nursing units are now required to submit their staff meeting minutes with HAPU discussions to the nursing administration office. Unit managers also include HAPU initiative in their QI projects.

Challenges

Inconsistent dissemination of information to nursing staff and inconsistent submission of meeting minutes and QI reports to the nursing administration office. Follow-ups are being sent out by the Chief Nursing Officer reminding managers to continue discussions with their staff about HAPU. They are also reminded to continue submitting copies of their staff meeting minutes and QI reports.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * | Yes |

Achievement Value | 1.00 |

Optional Milestone: Optional Milestone: 10. 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 |

Achievements

• Submitted Best Practice document to Safety Net Institute (SNI) in December 2011
• New HAPU QI coordinator included in the SNI HAPU ListServ
• Participated in CALNOC learning opportunities and benchmarking activities

Future Plans

• Submission of required reports
• Continue to participate in future learning opportunities

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: 11. Report HAPU stage III or greater to California Dept. of Public Health (CDPH)
(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]

Achievements

• Reported six HAPU cases to CDPH on the following dates: 07/25/11, 10/06/11, 12/09/11, 1/20/12, 4/18/12, and 5/11/12.

Challenges

• None

Future Plans

• Continue to report

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [Yes]

Achievement Value [1.00]

Optional Milestone: 12. Report HAPU Prevalence to CDPH
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * [ ]

Denominator (if absolute number, enter "1") * [ ]

Achievement [N/A]

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: * [No]

Prevalence surveys were conducted during DY7. See Prevalence of Stage II, III, IV or Unstageable Pressure Ulcers milestone for the results.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * [ ]

Achievement Value [N/A]

Optional Milestone: 13. Begin PDSA rapid change cycles
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * [ ]

Denominator (if absolute number, enter "1") * [ ]

Category 4: Hospital-Acquired Pressure Ulcer Prevention

Achievement

N/A

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:

*

The HAPU project at SCVMC is a robust program. Both the nursing and medical staff members are on-board when it comes to HAPU prevention. The program had many useful tools to track and prevent HAPUs at SCVMC. The tools in the program were strong as "standalone" tools for prevention and tracking, but were not coordinated in a way that provided a complete and comprehensive method that could be used as a standard across the hospital. The HAPU Management team underwent PDSA change cycle to modify the way HAPUs are tracked at SCVMC in DY7.

Plan

The team identified the individual tools we had in our arsenal. The tools that needed revision were identified as follows:

- High Risk Skin Condition Tracking Tool- this skin risk tracking tool is used in the units throughout the patient stay to identify and track patients who have high risk of developing pressure ulcer.
- Photo Form- Photo Form is used to capture the skin condition in photos
- Turn Log and Turn Clock- the turn log is used to document when patients are turned. The turn clock identifies when patients should be turned and provides a place to document the turns when they are made.

The HAPU Team identified that the High Risk Skin Condition Tracking Tool was the tool needing major revision based on ambiguity of the form and RNs' confusion on how to use the form, what should be tracked, and how often the data should be collected and reported to the HAPU team for analysis and management oversight.

Do

What the HAPU Team did was a complete overhaul of the skin tracking tool by clarifying what should be tracked and included on the form, identifying who "owns" the form, and where and when the form should be sent for reporting. Once the form's initial overhaul was completed and agreements between executive nursing management was agreed upon and "buy in" was clear, the HAPU team took the skin tracking form to the floor Nurse Management/Assistant Nurse Management teams for review and buy in on the suggested revisions. This meeting identified more clarifications previously overlooked. Taking suggestions back to executive management and making other continued revisions, these revisions went back and forth many times until a final consensus was reached and the form was finalized.

The other form, Photo Form, did not have an anatomical illustration for easy identification of the pressure ulcer sites. The third tool, Turn log and Turn Clock, was found not readily accessible to all care team members. There was no systematic way to keep track of turns made on patients. The struggle was finding the right location for the form for all care members to see. It was in a binder at the nursing station but it was not updated timely. As a result, the Turn Log was moved to the care plan section of the chart but the access to the form was limited if someone else had the chart.

Study

The HAPU team had to identify a rapid way to report to the hospital staff on progress and status of high risk patients. Using methods from the Sepsis Team, the designated data analyst developed a "home grown" access read only database to act as a "dashboard" style reporting tool that can be easily accessed by floor RN management and executive nursing management.

The HAPU Team agrees that having standard reporting format will keep everyone on track by utilizing and reviewing the same report. The analyst presented the dashboard and one reporting format was approved by executive and staff management as the best method of reporting quickly. The dashboard features "real-time" reporting availability that is updated once a week. The dashboard reports include: RN comments on admission, transfer locations logistics, stage, and initial Braden Scale measures to highlight a few. Currently, this dashboard is in the final testing stages and piloting on the 3Surg unit has completed.

For the Photo Form, anatomical body illustrations were added and it underwent two revisions in seven months. The Turn Clock and Turn Log was permanently printed on patients' white board in the room so it is visible and accessible to all caregivers. The patient and the family are now included and involved in tracking patients' turns.

Act

These tools are now in place and are being used by the nursing units except for the revised High Risk Skin Tracking Tool, which is expected to be adopted in early part of DY8. The delay is due to the numerous revisions made on the form to better capture outcome measurement. The HAPU Team will continue to monitor the use of these tools.

Conclusion

The Plan, Do, Study, and Act (PDSA) change cycle model was used to test the best method to identify patients at risk for developing pressure ulcer, track their progress and document the actions taken. The Photo Form, Turn Log and Turn Clock are now in use. The team now successfully monitors pressure ulcers in the facility through the use of these tools.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * Yes

Achievement Value   1.00

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

Category 4: Stroke Management

REPORTING ON THIS PROJECT: * [　　　　　　]

Below is the data reported for the DPH system.
Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).
* [ ] The yellow boxes indicate where the DPH system should input data
[ ] The black boxes indicate Milestones and will automatically populate and flow to summary sheets
[ ] The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
populate and flow to summary sheets

Stroke Management

DY Total Computable Incentive Amount: * [　　　　　]

Incentive Funding Already Received in DY: * [　　　　　]

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [　　　　　]

Denominator (if absolute number, enter "1")   * [　　　　　]

　Achievement   [N/A]

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: * [　　　　　]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [　　　　　]

　Achievement Value   [　　　　　]

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [　　　　　]

Denominator (if absolute number, enter "1")   * [　　　　　]

　Achievement   [N/A]

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: * [　　　　　]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [　　　　　]

　Achievement Value   [　　　　　]

DSRIP Semi-Annual Reporting Form

Category 4: Stroke Management

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * ☐

Denominator (if absolute number, enter "1") * ☐

　Achievement N/A

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: * ☐

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * ☐

　Achievement Value

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * ☐

Denominator (if absolute number, enter "1") * ☐

　Achievement N/A

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: * ☐

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * ☐

　Achievement Value

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * ☐

Denominator (if absolute number, enter "1") * ☐

　Achievement N/A

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: * ☐

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * ☐

　Achievement Value

DSRIP Semi-Annual Reporting Form

Category 4: Stroke Management

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

    Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

    Achievement Value   [   ]

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

Category 4: Venous Thromboembolism (VTE) Prevention and Treatment

REPORTING ON THIS PROJECT: *

Below is the data reported for the DPH system.
Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).

* The yellow boxes indicate where the DPH system should input data
The black boxes indicate Milestones and will automatically populate and flow to summary sheets
The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically populate and flow to summary sheets

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Venous Thromboembolism (VTE) Prevention and Treatment

DY Total Computable Incentive Amount: *

Incentive Funding Already Received in DY: *

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

Category 4: Venous Thromboembolism (VTE) Prevention and Treatment

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   *

Denominator (if absolute number, enter "1")   *

Achievement   N/A

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: *

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

Achievement Value

Category 4: Venous Thromboembolism (VTE) Prevention and Treatment

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

   Achievement Value   [   ]

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [   ]

Denominator (if absolute number, enter "1")   * [   ]

   Achievement   [N/A]

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: * [   ]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [   ]

   Achievement Value   [   ]

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Santa Clara Valley Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

Category 4: Falls with Injury Prevention

REPORTING ON THIS PROJECT: * [_____]

Below is the data reported for the DPH system.
** Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes',
please type in all of your DY milestones for the project below and report data in the indicated boxes (*).*

* ☐ The yellow boxes indicate where the DPH system should input data
☐ The black boxes indicate Milestones and will automatically populate and flow to summary sheets
☐ The blue boxes show progress made toward the Milestone ("Achievement Value") and will automatically
populate and flow to summary sheets

Falls with Injury Prevention

DY Total Computable Incentive Amount: * [_____]

Incentive Funding Already Received in DY: * [_____]

Prevalence of patient falls with injuries (Rate per 1,000 patient days)

Numerator   * [_____]

Denominator   * [_____]

   Prevalence Rate   [N/A]

Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

[   ]

DY Target (from the DPH system plan)   * [_____]

% Achievement of Target   [N/A]

Achievement Value   [_____]

Optional Milestone: _____

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)   * [_____]

Denominator (if absolute number, enter "1")   * [_____]

   Achievement   [N/A]

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: * [_____]

[   ]

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone   * [_____]

Achievement Value   [_____]

Category 4: Falls with Injury Prevention

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

Achievement   N/A

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: *

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

Achievement Value

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

Achievement   N/A

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: *

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

Achievement Value

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

Achievement   N/A

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: *

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

Achievement Value

Category 4: Falls with Injury Prevention

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

Achievement   N/A

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: *

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

Achievement Value

Optional Milestone: _____
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) *

Denominator (if absolute number, enter "1") *

Achievement   N/A

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: *

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

Achievement Value