UNIVERSITY OF CALIFORNIA, DAVIS

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SANTA BARBARA • SANTA CRUZ

OFFICE OF THE CHIEF MEDICAL OFFICER
UC Davis Medical Center
2315 Stockton Boulevard
Sacramento, California 95817

September 25, 2012

California Department of Health Care Services
1501 Capitol Avenue, Suite 6001
P.O. BOX 997413, MS 0000
Sacramento, CA 95899-7423

ATTENTION:

Neal Kohatsu, M.D., M.P.H., Medical Director
Leonard Finocchio, Dr. P.H., Associate Director
Brian Hansen, Health Reform Advisor

Please find attached the DY-7 Second Semi-Annual Report for the University of California, Davis Medical Center Delivery System Reform Incentive Pool Proposal for the California Section 1115(a) Medicaid Demonstration.

Sincerely,

Allan Siefkin M.D.

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cc:

Ann Madden Rice, Chief Executive Officer, UC Davis Medical Center
Timothy Maurice, Chief Financial Officer, UC Davis Health System
Terry Leach, Policy and Legislative Director, Office of the President, Health Sciences and Services, University of California
Michael Thompson, Director, Healthcare Operations and Tech Services, Office of the President, Health Sciences and Services, University of California
John Semerdjian, Data Analyst, California Health Care Safety Net Institute

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:**	The University of California, Davis Medical Center
* **REPORTING YEAR:**	DY 7
* **DATE OF SUBMISSION:**	9/26/2012

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	$ -
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:	$ -
Category 2 Projects	
Expand Medical Homes	$ -
Expand Chronic Care Management Models	
Redesign Primary Care	
Redesign to Improve Patient Experience	
Redesign for Cost Containment	
Integrate Physical and Behavioral Health Care	
Increase Specialty Care Access/Redesign Referral Process	
Establish/Expand a Patient Care Navigation Program	
Apply Process Improvement Methodology to Improve Quality/Efficiency	$ -
Improve Patient Flow in the Emergency Department/Rapid Medical Evaluation	
Use Palliative Care Programs	
Conduct Medication Management	$ 504,875.00
Implement/Expand Care Transitions Programs	$ -
Implement Real-Time Hospital-Acquired Infections (HAIs) System	
TOTAL CATEGORY 2 INCENTIVE PAYMENT:	$ 504,875.00
Category 3 Domains	
Patient/Care Giver Experience *(required)*	$ -
Care Coordination *(required)*	$ 1,689,187.50
Preventive Health *(required)*	$ 1,689,187.50
At-Risk Populations *(required)*	$ 1,689,187.50
TOTAL CATEGORY 3 INCENTIVE PAYMENT:	$ 5,067,562.50
Category 4 Interventions	
Severe Sepsis Detection and Management *(required)*	$ 388,208.33
Central Line Associated Blood Stream Infection Prevention *(required)*	$ 317,625.00
Surgical Site Infection Prevention	$ 317,625.00
Hospital-Acquired Pressure Ulcer Prevention	$ 476,437.50
Stroke Management	
Venous Thromboembolism (VTE) Prevention and Treatment	
Falls with Injury Prevention	
TOTAL CATEGORY 4 INCENTIVE PAYMENT:	$ 1,499,895.83
TOTAL INCENTIVE PAYMENT	$ 7,072,333.33

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: The University of California, Davis Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/26/2012

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
Per the instructions of CAPH/SNI, this section will be completed in the annual report due on October 31, 2012.

Summary of DPH System's Participation in Shared Learning
Per the instructions of CAPH/SNI, this section will be completed in the annual report due on October 31, 2012.

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: The University of California, Davis Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/26/2012

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:		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

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:		

Category 1 Summary Page

Implement and Utilize Disease Management Registry Functionality

Process Milestone:	Milestone 1.4: Implement a system to accommodate newly diagnosed chronic disease management patients within at least 1 primary care clinic.	Yes
Achievement Value		*1.00*
Process Milestone:	Milestone 1.5: Plan development of tethered registry to capture patient enrollment in Chronic Disease Management Program.	Yes
Achievement Value		*1.00*
Process Milestone:	Milestone 1.6: Patient experience report with PRC and paper-based companion survey outcomes to be completed.	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:		$ 7,972,500.00
Total Sum of Achievement Values:		3.00
Total Number of Milestones:		3.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 7,972,500.00
Incentive Funding Already Received in DY:		$ 7,972,500.00
Incentive Payment Amount:		$ -

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:		

Category 1 Summary Page

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

Process Milestone:	Milestone 2.3: Develop a plan to stratify patient outcomes using REAL data and strategy to link to quality data.	Yes
Achievement Value		*1.00*
Process Milestone:	Milestone 2.4: Patient experience questionnaire to be designed and tested using a sample set of patients across demographics in all clinical areas where data is collected.	Yes
Achievement Value		*1.00*
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:	$ 7,972,500.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	2.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 7,972,500.00
Incentive Funding Already Received in DY:	$ 7,972,500.00
Incentive Payment Amount:	$ -

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:		

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 Payment Received in DY:		$ -
Incentive Payment Amount:		

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:		$ -
Incentive Payment Amount:		

Category 1 Summary Page

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:		

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:		

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: The University of California, Davis Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/26/2012

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:	Milestone 5.4: Develop a timeline and plan for submission to PCMH application for Primary Care Network sites.	Yes
Achievement Value		*1.00*
Process Milestone:	Milestone 5.5: Development of patient experience survey using PCMH criteria to be designed and tested.	Yes
Achievement Value		*1.00*
Process Milestone:	Milestone 5.6: Design a seasonal influenza notification system using the EHR MyChartTM functionality to send messages to all MyChartTM enrolled patients on the importance of immunizations.	Yes
Achievement Value		*1.00*
Process Milestone:	Milestone 5.7: Design of MyChartTM influenza notification report for provider/staff use.	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:	$ 5,048,750.00
Total Sum of Achievement Values:	4.00
Total Number of Milestones:	4.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 5,048,750.00
Incentive Funding Already Received in DY:	$ 5,048,750.00
Incentive Payment Amount:	$ -

Category 2 Summary Page

Expand Chronic Care Management Models

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

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:		

Category 2 Summary Page

Redesign to Improve Patient Experience

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

Redesign for Cost Containment

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

Integrate Physical and Behavioral Health 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:		

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:		

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:	Milestone 6.3: Develop early-warning systems within the UCDMC EHR to act upon identified problems.	Yes
Achievement Value		*1.00*
Process Milestone:	Milestone 6.4: LLS Just-in-Time (JIT) training to at least 2 multidisciplinary teams for specific projects.	Yes
Achievement Value		*1.00*
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:	$ 5,048,750.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	2.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 5,048,750.00
Incentive Funding Already Received in DY:	$ 5,048,750.00
Incentive Payment Amount:	$ -

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:	Milestone 4.3: Implement services to improve continuity of medication use (ie, medication optimization, discharge medication reconciliation, after-discharge follow up and education) for patients with heart failure or who are discharged on warfarin.	Yes
Achievement Value		*1.00*
Process Milestone:	Milestone 4.4: Provide services to improve continuity of medication use to at least 50% of patient with heart failure or who are discharged on warfarin.	0.57
Achievement Value		*1.00*
Process Milestone:	Milestone 4.5: Implement safeguards in EHR to ensure compliance with criteria for safe use of Black Box Warning medications.	Yes
Achievement Value		*1.00*
Improvement Milestone:	Milestone 4.6: Smart infusion pumps are implemented for remaining 25% of infusions (PCA, epidural, and syringe pumps).	Yes
Achievement Value		*1.00*
Improvement Milestone:	Milestone 4.7: Planning is completed for full implementation of bedside barcode scanning.	Yes
Achievement Value		*1.00*
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ 4,543,875.00
Total Sum of Achievement Values:	5.00
Total Number of Milestones:	5.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 4,543,875.00
Incentive Funding Already Received in DY:	$ 4,039,000.00
Incentive Payment Amount:	$ 504,875.00

Category 2 Summary Page

Implement/Expand Care Transitions Programs

Process Milestone:	Milestone 3.2: Expand ED case management to seven days per week (infrastructure-process measure).	Yes
Achievement Value		*1.00*
Process Milestone:	Milestone 3.3: Plan the construction of a tethered registry to EHR to identify and manage high risk patients (innovation and redesign-process measure).	Yes
Achievement Value		*1.00*
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:	$ 5,048,750.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	2.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 5,048,750.00
Incentive Funding Already Received in DY:	$ 5,048,750.00
Incentive Payment Amount:	$ -

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:		

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: The University of California, Davis Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/26/2012

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 contract 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:	$ 3,378,375.00
Total Sum of Achievement Values:	1.00
Total Number of Milestones:	1.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 3,378,375.00
Incentive Funding Already Received in DY:	$ 3,378,375.00
Incentive Payment Amount:	$ -

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:	$ 3,378,376.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	2.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 3,378,376.00
Incentive Funding Already Received in DY:	$ 1,689,188.50
Incentive Payment Amount:	$ 1,689,187.50

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:	$ 3,378,376.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	2.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 3,378,376.00
Incentive Funding Already Received in DY:	$ 1,689,188.50
Incentive Payment Amount:	$ 1,689,187.50

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:	$ 3,378,376.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	2.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 3,378,376.00
Incentive Funding Already Received in DY:	$ 1,689,188.50
Incentive Payment Amount:	$ 1,689,187.50

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: The University of California, Davis Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/26/2012

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 (%)		0.45
Achievement Value		*1.00*
Optional Milestone:	Milestone 7.4: Develop and implement Best Practice Alerts within the UCDMC EHR for early sepsis recognition.	Yes
Achievement Value		*1.00*
Optional Milestone:	Milestone 7.5: Report at least 6 months of data collection on sepsis resuscitation bundle to SNI for purposes of establishing a baseline and setting benchmarks.	0.45
Achievement Value		*1.00*
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		
Optional Milestone:	-	N/A
Achievement Value		
DY Total Computable Incentive Amount:		$ 2,329,250.00
Total Sum of Achievement Values:		3.00
Total Number of Milestones:		3.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 2,329,250.00
Incentive Funding Already Received in DY:		$ 1,941,041.67
Incentive Payment Amount:		$ 388,208.33

Category 4 Summary Page

Central Line Associated Blood Stream Infection Prevention *(required)*

Compliance with Central Line Insertion Practices (CLIP) (%)		0.97
Achievement Value		1.00
Optional Milestone:	Milestone 8.2: Report at least 6 months of data on CLIP to SNI for the purposes of establishing a baseline and setting benchmarks.	0.97
Achievement Value		*1.00*
Optional Milestone:	Milestone 8.3: Report at least 6 months of data collection on CLABSI to SNI for the purposes of establishing the baseline and setting benchmarks.	0.00
Achievement Value		*1.00*
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:		$ 1,905,750.00
Total Sum of Achievement Values:		3.00
Total Number of Milestones:		3.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 1,905,750.00
Incentive Funding Already Received in DY:		$ 1,588,125.00
Incentive Payment Amount:		$ 317,625.00

Category 4 Summary Page

Surgical Site Infection Prevention

Rate of surgical site infection for Class 1 and 2 wounds (%)		0.02
Achievement Value		1.00
Optional Milestone:	Milestone 9.3: Install TheraDoc software and train staff to streamline surgical site infection surveillance.	Yes
Achievement Value		*1.00*
Optional Milestone:	Milestone 9.4: Report at least 6 months of data collection on SSI to SNI for purposes of establishing a baseline and setting benchmarks.	0.02
Achievement Value		*1.00*
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:		$ 1,905,750.00
Total Sum of Achievement Values:		3.00
Total Number of Milestones:		3.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 1,905,750.00
Incentive Funding Already Received in DY:		$ 1,588,125.00
Incentive Payment Amount:		$ 317,625.00

Category 4 Summary Page

Hospital-Acquired Pressure Ulcer Prevention

Prevalence of Stage II, III, IV or unstagable pressure ulcers (%)		0.01
Achievement Value		1.00
Optional Milestone:	Milestone 10.3: Share data, promising practices and findings with SNI to foster shared learning and benchmarking across California public hospitals.	Yes
Achievement Value		*1.00*
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		
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:		$ 1,905,751.00
Total Sum of Achievement Values:		2.00
Total Number of Milestones:		2.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 1,905,751.00
Incentive Funding Already Received in DY:		$ 1,429,313.50
Incentive Payment Amount:		$ 476,437.50

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 Payment Already Received in DY:		$ -
Incentive Payment Amount:		

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: The University of California, Davis Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/26/2012

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: * $ 7,972,500.00

Incentive Funding Already Received in DY: * $ 7,972,500.00

Process Milestone: Milestone 1.4: Implement a system to accommodate newly diagnosed chronic disease management patients within at least 1 primary care clinic.
(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 1.4: System to accommodate patients implemented.

The goal of the UC Davis Medical Center's (UCDMC's) Chronic Disease Management (CDM) Program is to ensure all new and existing patients have exceptional access to disease management support from the point of diagnosis through ongoing care. As of March 2012, the Chronic Disease Management and Education Programs were expanded to the Elk Grove Primary Care Network site and include support for diabetes, congestive heart failure, and depression. Patients may be referred to CDM through a primary care provider (PCP), a specialty provider, or self-referral. Upon referral, an order is generated for the CDM program in Epic or by phone. The patient referral is then screened and assessed by a coordinator and program nurse. Services, such as one-on-one counseling, a group session, or a consultation with the PCP, are offered and scheduled. Once the patient enrolls in the service, he/she is assessed for readiness, an action plan, and a self-management goal. The outcomes of the session (ie, care plan and intervention) are documented for the PCP. From this point, the CDM team co-manages the patient with the PCP to follow up on the care plan and desired outcomes. Care management/care plan communication and documentation structure were evaluated in March 2012 for integration into the Epic electronic health record. To supplement on-site clinic support, CDM has created a website to offer providers resources for treating patients with chronic disease (http://www.ucdmc.ucdavis.edu/chronicdisease/welcome_providers.html). The site has been developed in response to physician requests and will keep growing to provide more guideline-based chronic disease care that supports patient self-management. Providers can learn how to refer their patients for self-management education classes as well as obtain self-management educational materials. Providers may access services by making a referral in the Epic order entry system or calling the CDM program for direct intake. Additionally, a website has been developed for patients (http://www.ucdmc.ucdavis.edu/chronicdisease/ welcome_patients.html). The transition from DY-6 to DY-7 goals of this specific project was a challenge. Program expansion required building infrastructure, which taxed financial and human resources. Some members of the Elk Grove clinic needed time for trust building and were initially skeptical that the interventions would work. Engaging and educating primary care providers on concepts of the patient-centered medical home, the redesign of current models of care, and emphasizing the role of the CDM Education and Care Programs took time but eventually received support from providers and leadership through education and reports highlighting positive outcome data.

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

Achievement Value 1.00

Category 1: Implement and Utilize Disease Management Registry Functionality

Process Milestone: Milestone 1.5: Plan development of tethered registry to capture patient enrollment in Chronic Disease Management 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

Metric 1.5: Plan of tethered registry completed.

The Chronic Disease Management (CDM) Tethered Registry Workgroup is led by members from electronic medical record reporting, primary care (family practice and general internal medicine), CDM, and the clinical registry team. The group meets biweekly to discuss registry needs and expansion to include reporting of Category 3 metrics related to care coordination, preventive health, and at-risk populations. This workgroup is critical in bridging from the current "home-grown" non-tethered registry system to the broader proposed registry, which will draw from a variety of data sources. We have created an extension of the non-tethered registry with Health Information Technology (HIT) to develop more robust registry reports directly in Epic. These reports include reporting workbench, which generates doctor-specific reports that indicate which patients are out of range on clinical parameters, and practice management reports, which track resource utilization. The physician-specific workbench reports produce patient-level data on a variety of clinical parameters, including hemoglobin A1c, LDL, blood pressure, and microalbumin/creatinine ratio. When physicians have this information available, they are empowered to follow up with individual patients on specific clinical needs, such as medication, education, and lifestyle choices related to diet and exercise. The reporting workbench can also generate practice management reports that show the number of diabetes patients accessing specific services such as retinal screening, foot exams, consultation with a nutritionist, or depression screening. These reports can be very useful for managing resources needed by a CDM population. We are working toward expanding this capacity to other Category 3 metrics and chronic disease programs using the tethered meta-registry. In working to achieve sustainable registries, we encountered problems with HIT support, including finding the right level of expertise among report writers and receiving prioritization of this project by HIT. To overcome these challenges, we recruited a new Epic report writer. HIT is critical to the advancement of this project and may be hampered by the prioritization of the 2013 Epic upgrade.

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

Process Milestone: Milestone 1.6: Patient experience report with PRC and paper-based companion survey outcomes to be completed.

(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 1.6: Patient experience report developed using PRC in comparison with paper-based survey results.

The Care Coordination/Care Management Steering Committee oversees chronic disease management (CDM) patient experience reporting and is represented by key leaders in clinical operations, patient care services, home health, hospice, pharmacy, nursing, and clinical quality improvement. Representation from marketing has been required to facilitate the addition of questions in the UC Davis Medical Center's (UCDMC's) current patient satisfaction survey. The objective of

Category 1: Implement and Utilize Disease Management Registry Functionality

this project is to enhance understanding of patient experiences in CDM by capturing data on satisfaction with care instructions and home management as well as satisfaction with CDM program services, specifically “In Charge, In Control” and “Dining with Diabetes.” The following questions are being tracked in our patient satisfaction survey to assess chronic disease self-management: “How would you rate the instructions provided about caring for yourself/your family member at home?” has been available since 2006, but “How would you rate your ability to manage your/your family member’s care at home?” was created specifically for CDM in 2011. Adding the CDM questions required leveraging marketing to request that a new item be added to the existing survey. Additionally, collecting the existing paper-based experience surveys required significant time for data entry, which may be a barrier to sustaining patient experience reporting for CDM.

In DY-7, 59.4% of respondents (n = 5,090) who received outpatient primary care at UCDMC rated the instructions provided to them about caring for themselves or a family member at home as “excellent”; 52.9% of respondents (n = 5,302) rated their ability to manage their care or the care of a family member at home as “excellent.” Of the 76 CDM patients who completed “In Charge, In Control” surveys, 73% said they felt extremely informed about diabetes, but only 54% felt extremely confident about their ability to manage their diabetes. One patient specifically requested more medication information, and another requested more “tailored” education regarding individual situations. Following up on these suggestions could improve patient self-efficacy. Of the 160 patients who completed the “Dining with Diabetes” survey, more than 50% of respondents rated discussions about counting carbohydrates, identifying carbohydrates, and timing meals as “excellent.” Several patients specifically requested more assistance with setting dietary goals to improve their diabetes. Although reviewing the results from the PRC and paper-based surveys provides a broad view of patient experience, we are currently unable to link the respondents who answered the PRC surveys to the CDM patient satisfaction instruments. Data collection in DY-8 may need to be restructured to ensure that all data captured are relevant to the experience of CDM patients. This may involve consolidating self-management and education satisfaction questions in a single survey that can be directly targeted to CDM patients.

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: _____
(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

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: 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

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: 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

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: The University of California, Davis Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/26/2012

REPORTING ON THIS PROJECT: * Yes

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: * $ 7,972,500.00

Incentive Funding Already Received in DY: * $ 7,972,500.00

Process Milestone: Milestone 2.3: Develop a plan to stratify patient outcomes using REAL data and strategy to link to quality data.
(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 2.3: Strategic plan developed.

The goal of this project is to collect race, ethnicity, and language (REAL) data to better understand health disparities in clinical outcomes and design interventions to address them. This project is led by a steering committee divided into three work groups: 1) a training and development work group focusing on accuracy of data collection; 2) a health information technology (HIT) work group, which validates the current portal selections for patients and provides updates to include new ones, such as religious preference and sexual orientation; and 3) a communications work group, which develops internal and external communications strategies to promote the importance of collecting REAL data in the UC Davis Primary Care Network. In February 2012, a plan was drafted to reduce health disparities that focuses on care coordination (Project 12), preventive health (Project 13), and at-risk population (Project 14) services by race/ethnicity, gender, and age. Once a disparity is identified in one of these areas, the Steering Committee will work to develop an intervention plan that is culturally relevant for the affected population. To improve data collection, monthly management reports have been created to track the accuracy and completeness of REAL data elements (ie, reducing proportion of fields marked “unavailable” or “unknown”). This has involved finalizing REAL reports and posting them on the UC Davis Medical Center's intranet so that they are accessible to stakeholders at a variety of clinical sites.

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

Achievement Value: 1.00

Process Milestone: Milestone 2.4: Patient experience questionnaire to be designed and tested using a sample set of patients across demographics in all clinical areas where data is collected.
(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 2.4: Patient experience questionnaires designed and test implemented.

A patient experience questionnaire was designed to evaluate the race, ethnicity, and language (REAL) data collection process and initiated with patients across the UC Davis Medical Center (UCDMC). To understanding how patients are approached for REAL data and address possible training needs, a random sample of 25 adult patients is drawn per clinical site and invited to participate in a telephone survey. To be eligible for the survey, the patient has to have complete REAL data collected from a clinical encounter received in the last 30 days. The results of the survey are evaluated to identify needed changes in how patients are approached for their REAL data (ie, asked in a private setting, offered an explanation of why the data are important, provided written materials when asked), with staff training organized around areas where performance improvement is needed. The goals of REAL patient experience data collection had to be aligned with other trainings of UCDMC staff regarding diversity awareness. Developing a validation system to check data accuracy is still pending. It is also important to note that the REAL data collection process, which involved a dedicated staff member making outreach phone calls to patients, was difficult given the number of sites involved. After testing and completing electronic Survey Monkey questionnaire design and data entry, it was determined that the process would only continue until the CG-CAHPS cultural competence question set could be implemented and sustained. To continue to make progress in future analyses of health disparities using REAL data, a goal in DY-8, ongoing support form Health Information Technology (HIT) will be critical to build and modify reports. This will be especially important as the Office of Statewide Health Planning and Develop enriches patient demographics with social characteristics, such as religious preference and gender identification.

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

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

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

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

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: The University of California, Davis Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/26/2012

REPORTING ON THIS PROJECT: * Yes

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: * $ 5,048,750.00

Incentive Funding Already Received in DY: * $ 5,048,750.00

Process Milestone: Milestone 5.4: Develop a timeline and plan for submission to PCMH application for Primary Care Network sites.
(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 5.4: Timeline and plan for PCMH NCQA application submission completed.

The Patient-centered Medical Home (PCMH) Steering Group, the Care Coordination and Care Management Steering Committee, the Subgroup on Care Transitions, and the Subgroup on Unit-based Care Models were brought together to develop the NCQA PCMH application. These groups were charged to address the culture change, structural improvements, and patient-centeredness in ambulatory care needed in a competitive application for PCMH designation. Key care components to be addressed in the application included: 1) restructuring of current workforce models and teams (ie, optimizing the medical assistant model, increasing the use of senior LVNs in clinical practice); 2) optimizing the use of a central RN triage function dedicated to primary care practice sites throughout the Northern California region; 3) organizing care teams (ie, RN, pharmacist, social worker, chronic disease educator, and care manager) by region to provide on-site education and patient/provider support in self-management; and 4) developing a system of centralized care management that includes home care, discharge planning, managed care, and chronic disease management. The goal of this system is to ensure seamless hand-offs and reductions in avoidable readmissions, improve patient outreach, reduce unnecessary emergency department visits, and further enhance the support for population management as evidenced in the Category 3 projects. Between July and September 2011, a steering committee was formed to develop models to meet NCQA criteria and the goals of the Triple Aim. Between October and December 2011, educational presentations were developed for Primary Care Network (PCN) providers to ensure acceptance of the PCMH model; medical students, residents, fellows, faculty in academic practices, and clinic staff were invited to presentations on how the PCMH facilitates building accountable care organizations, creating new partnerships with health plans, securing a market advantage, and maximizing the patient experience with coordinated seamless care. One challenging assumption was that PCN sites would qualify for the designation without redesign work. Buy-in and support from PCN leadership with help of associate directors helped overcome resistance. Integration of PCMH model concepts into the UC Davis Medical Center's (UCDMC's) strategic plan helped refocus attention on the core features of the PCMH model. Project memebers took into consideration the optimization of staff roles, specifically the part of the medical assistant. There was some fear that clerical staff roles would be transitioned to clinical staff, creating anxiety and fear about job loss. A timeline and plan were developed for submission of the PCMH application for PCN sites, with work on the multi-site application beginning in January 2012. On June 26, 2012, NCQA approved the UCDMC application for recognition review.

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

Achievement Value: 1.00

Process Milestone: Milestone 5.5: Development of patient experience survey using PCMH criteria to be designed and tested.
(insert milestone)

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

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

Category 2: Expand Medical Homes

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 5.5: Patient experience survey using PCMH criteria completed.

The Patient Experience Officers' Team includes key stakeholders from marketing, clinical operations, patient relations, performance improvement, and chronic disease management and education. The charge of the team was to incorporate the CG-CAHPS Patient-centered Medical Home (PCMH) survey into existing survey instruments managed by Professional Research Consultants, Inc. (PRC), on behalf of the UC Davis Medical Center (UCDMC). The group worked extensively with Safety Net Institute to finalize core CG-CAHPS measures for DSRIP requirements and public reporting. UCDMC determined the PCMH (14 items) survey question set should be added. In October 2011, the core CG-CAHPS survey was successfully launched. The PCMH self-management questions were added to the survey in January 2012. The team is also working on establishing Patient and Family Experience Councils (PFECs) to determine patients' experience with PCMH models in collaboration with ExperiaHealth. Focus groups for patients and their families are being planned. Lastly, we are incorporating feedback from diabetes education through surveys completed by chronic disease management participants (Project 1.6) to enhance patient experience in the PCMH. In January 2012, the PCMH questions went live. In the first six months of 2012, 150 respondents from family practice, general internal medicine, and the Primary Care Network were surveyed with this question set for a total sample of 450. UCDMC's participation rate is close to 90%.

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

Category 2: Expand Medical Homes

Process Milestone: Milestone 5.6: Design a seasonal influenza notification system using the EHR MyChart™ functionality to send messages to all MyChart™ enrolled patients on the importance of immunizations.

(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 5.6: MyChartTM Influenza notification plan implemented.

The focus of this project was to notify patients of influenza season and the importance of immunization by capitalizing on the electronic benefits of the MyChart system while accommodating patients who do not subscribe to MyChart. Despite some concern about using MyChart to push messages and health care alerts to patients, the collaborative work group, which included key Health Information Technology analysts, was able to initiate patient notification with a pilot at one clinic site. Strong primary care provider and practice support reinforced the value of the group's work. As an alternative to pushing messages, the UC Davis Medical Center's (UCDMC's) MyChart launching page provided a blanket announcement to all MyChart subscribers about the importance of influenza vaccination during flu season. Additionally, telephone reminder calls were made to patients outside the MyChart system to maximize the spread of the immunization message. For DY-7, the overall influenza immunization rate during flu season (September 2011 – February 2012) among patients age 50 or older who had two primary care visits at UCDMC in the last year was 45.7% (Project 13.2). This compares to a HEDIS 2009 benchmark of 51%. The ability to capture and record information on patients who received a flu shot outside UCDMC continues to be a struggle.

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

Process Milestone: Milestone 5.7: Design of MyChart™ influenza notification report for provider/staff use.

(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 5.7: Design of MyChartTM influenza notification completed.

Best practice alerts on influenza immunization compliance have been available to providers since December 2010, and workbench reporting has been a functionality of the Epic electronic health record (EHR) since January 2011. Current practice is for providers at all primary care sites to review an influenza action report or census list during the "team huddle." In August 2011, emphasis was placed on having medical support staff use the report to guide patient education about influenza immunization. Medical assistants (MAs) and/or senior LVNs were trained to identify patients due for influenza immunization prior to rooming and to provide – as needed – education on the importance of the influenza vaccine and explanations of the different types of vaccine available. Staff were also trained to ask about vaccines received outside the UC Davis Medical Center. Between November 2011 and February 2012, MAs and LVNs were presented with an enhanced previsit planning workflow that included monitoring lists of patients with upcoming appointments to ensure that staff addressed patient questions in regard to immunization and managed related MyChart inquiries.

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) *	
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: *	

Category 2: Expand Medical Homes

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: The University of California, Davis Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/26/2012

REPORTING ON THIS PROJECT: * Yes

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: * $ 5,048,750.00

Incentive Funding Already Received in DY: * $ 5,048,750.00

Process Milestone: Milestone 6.3: Develop early-warning systems within the UCDMC EHR to act upon identified problems.
(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 6.3: Early-warning systems documented through dashboard reports.

An electronic screening alert was designed for the identification and management of severe sepsis/septic shock to aid in early identification of at-risk patients based on a “trigger” in the patient’s documented physiological findings and/or lab results. To assist in planning the screening alert, prior state workflow diagrams were created for the Emergency Department (ED), Intensive Care Units (ICUs), and Acute Care Units (ACUs) as well as the Rapid Response Team. Pharmacy and laboratory workflows were also assessed. A variety of electronic ordersets were developed for initiation upon the firing of a best practice alert. These include: 1) a severe sepsis screening orderset, 2) a severe sepsis treatment and monitoring orderset (based on Institute for Healthcare Improvement early goal directed therapy (EGDT) recommendations), and 3) a severe sepsis reassessment orderset (accompanied by a reassessment view). Pharmacy workflows were subsequently modified to expedite the availability of antibiotics in sepsis ordersets and lab values (including certified and validated ABG lactic acid lab analysis). Electronic notifications to the Rapid Response Team were initiated to support ED/ACU staff in treatment of patients.

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

Achievement Value: 1.00

Process Milestone: Milestone 6.4: LLS Just-in-Time (JIT) training to at least 2 multidisciplinary teams for specific projects.
(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 6.4: Training documentation provided, including the number of relevant providers/staff trained and/or number of trainings held and progress/result of the respective projects.

Various UC Davis Medical Center (UCDMC) Quality Initiative (QI) teams are developed and supported by Lean Six Sigma (LSS) Black Belts who provide them with just-in-time (JIT) training in quality improvement based on the DMAIC (Define-Measure-Analyze-Improve-Control) framework (ie, process, tools, philosophies and techniques from Lean and/or Six

Category 2: Apply Process Improvement Methodology to Improve Quality/Efficiency

Sigma methodologies). Additional training is also provided on the functions and roles of team members, communication skills, decision making, planning, and presenting team results to senior leadership. The Improve Severe Sepsis Detection and Management team training has focused on developing and deploying LSS methodology and techniques to achieve a significant reduction in patient mortality as it relates to severe sepsis and septic shock at UCDMC. Utilizing LSS gives participants in the Sepsis Improvement Collaborative (SIC) the opportunity to evaluate current process related to sepsis and develop process redesign. Twenty-eight UCDMC staff participated in LSS JIT training related to the SIC during DSRIP DY-7. Weekly SIC Steering Committee Meetings (three members) have been used to introduce various quality improvement tools and techniques related to the DMAIC framework. Key LSS JIT training elements include DMAIC overview, project charters, QI team roles, setting SMART goals, process mapping, data collection planning, process observations, data analysis techniques, root cause analysis, QI intervention planning, and process control plan. Monthly SIC meetings (25 staff members) incorporate various quality improvement tools and techniques based on the DMAIC framework as needed. The Environmental Services (EVS) Inpatient Discharge Process Team focused on the improvement of departmental efficiencies with the goal of decreasing discharge cleaning turnaround time and improving process quality. Specifically, this quality initiative utilized LSS methodologies to fully leverage EVS metrics (both logistics and quality) and engage all levels of EVS staff. Twenty UCDMC staff participated in LSS JIT training related to the EVS QI during DSRIP DY-7 and implemented a newly designed quality program for EVS management and front-line staff. This process began on February 9, 2012, with a Kaizen Event that included all levels of EVS staff. The team subsequently implemented a newly designed tracking system for EVS management to monitor and act upon response time to inpatient discharges. The EVS QI team members worked on a variety of DMAIC tools and techniques throughout their engagement in the required LSS JIT training.

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

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

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: The University of California, Davis Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/26/2012

REPORTING ON THIS PROJECT: * Yes

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

Conduct Medication Management

DY Total Computable Incentive Amount: * $ 4,543,875.00

Incentive Funding Already Received in DY: * $ 4,039,000.00

Process Milestone: Milestone 4.3: Implement services to improve continuity of medication use (ie, medication optimization, discharge medication reconciliation, after-discharge follow up and education) for patients with heart failure or who are discharged on warfarin.

(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 4.3: Pharmacist and nurse hired and begin providing continuity of medication use services.

We chose to make heart failure (HF) patients our clinical focus in improving continuity of medication use for DY-7. The clinical champion for this project is Kathleen Tong, MD; she is supported by a nurse practitioner, Kristin Todd, RN, NP, and pharmacist, Daniel Louie, PharmD, who both provide patient advocacy, maintain an active list of HF patients, offer patient education, and conduct telephone follow-up. Both Ms. Todd and Mr. Louie were specifically trained to assist in the educational and transition of care needs of HF patients. The training curriculum was based on AHA/ACC heart failure guidelines, HFSA guidelines for patients' self-care, and the core measures for HF patients. We also included literature on existing transition of care programs such as the Mary Naylor model and Project RED. Ms. Todd also used the AAHFN handbook for HF nurses. The following protocol was developed to identify and intervene upon targeted HF patients:

i. Admitted patients are reviewed to determine if they have a history of HF or a new diagnosis: new patients are actively followed by the Transition of Care (TOC) Team (intervention group) and patients with a history of HF are followed for longitudinal tracking

ii. Active Transition Care Team patients are the population of interest and include: 1) new cases and HF, 2) HF exacerbations not on dialysis, and 3) no HF exacerbation but at least one risk factor for readmission (eg, HF admission in last three months; non-compliance; drug/alcohol history; no social support, primary care physician, or transportation; history of no shows).

iii. For TOC Team population during hospitalization

1. Thorough chart review completed
2. Hospital service contacted
3. Need for education assessed and completed

iv. For TOC Team population during discharge

1. Social worker and discharge planner invited to address needs
2. TOC Team completes discharge medication reconciliation

v. For TOC Team population post-discharge

1. TOC Team makes follow up call in 2-3 days and 1 week following discharge to ensure patient establishes care with cardiologist/PCP
2. TOC Team assesses patient by documenting medication, weight, and signs/symptoms; addresses medication issues; and sends information to the PCP

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

Achievement Value: 1.00

Category 2: Conduct Medication Management

Process Milestone: Milestone 4.4: Provide services to improve continuity of medication use to at least 50% of patient with heart failure or who are discharged on warfarin.

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	235.00
Denominator (if absolute number, enter "1")	*	411.00
Achievement		0.57
If "yes/no" as to whether the milestone has been achieved, 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 4.4: Numerator: patients who received services (n=235), denominator: total number of targeted patients who are discharged during time frame (n=411) (DY-7 metric: 57%)

In DY-7, heart failure (HF) education services were provided to 57% of eligible patients (235 of 411), thereby allowing us to meet our milestone metric for Project 4.4 (ie, services delivered to at least 50% of eligible patients). Between August 1, when the project began, and December 31, 2011, services were provided to 50% of eligible patients (92 of 184). Between January 1, 2012 and June 30, 2012, services were provided to 63% of eligible patients (143 of 227). This project has reported success through the UHC/AAMC Best Practices for Better Care dashboard for 30-day HF readmissions, which ranked UC Davis Medical Center 5 of 58 with an observed readmission rate of 12.8% compared to a target of 15.8% over the period of October to December 2011. This project has successfully identified lists of HF patients that are of benefit to many different areas of the hospital, including research, case management, and chronic disease management. Several patients who have had readmissions have had successful, long outpatient courses after this team intervened, and educational materials have helped patients manage their care on their own. The HF Transition of Care Team is working with a DSRIP analyst to create automated reports for identifying patients. Manually managing the lists requires significant human resources. Another challenge has involved patients who are uninsured or underinsured. Specifically, arranging outpatient follow up for patients covered under Sacramento County and non-UCD managed Medi-Cal has been difficult. Completing forms to receive covered outpatient care often requires several stages of paperwork and multiple visits to eligibility offices. The project is limited in its resources to assist these patients, but staff have learned to coach them through county eligibility and motivate them to finish their paperwork. Another challenge relates to communicating with patients who have low health literacy and language barriers. These problems were addressed by using interpreters when possible and teaching at a sixth-grade level with simple instructional tools and the “teach back” method. Lastly, medication access is a problem for HF patients who have limited budgets—even a small co-pay can be a financial strain. We use generic drugs whenever possible, not finding it difficult to contrive an evidence-based drug regimen with generic medications. Potential barriers to project success include: 1) coverage provided 5 days per week: patients with short stays over the weekend may be missed; 2) patient payorship status: while we do our best to help patients get to appropriate resources, the fact remains that many patients are underinsured or under-resourced, and this directly impacts the level of success we can achieve with these patients; and 3) increasing number of elderly HF patients: as our target population increases, we must adjust and augment our team to meet their needs and ensure successful outpatient transitions.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	*	0.50
Achievement Value		1.00

Category 2: Conduct Medication Management

Process Milestone: Milestone 4.5: Implement safeguards in EHR to ensure compliance with criteria for safe use of Black Box Warning medications.

(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 4.5: Safeguards in place for all outpatient prescriptions for Black Box Warning (BBW) medications.

The purpose of the "black box warning" (BBW) system is to identify drugs that carry a significant risk of serious or even life-threatening adverse effects. Failure on the part of prescribers, nurses, and pharmacists to heed these warnings places patients at increased risk of having a bad outcome from taking these drugs. The UC Davis Medical Center Pharmacy Department teamed with the electronic health record (EHR) pharmacy analysts to provide a process to implement alerts, flags, and order details (eg, instructions, questions, lab results, and links) within the EHR to guide clinicians during the prescribing, ordering, dispensing, and administration of BBW medications. The maintenance and ongoing support phase of inpatient BBW medications began in June 2010, when retrospective data collection began for droperidol, haloperidol, and methadone to ensure regulatory and hospital compliance. During this month pregnancy alerts also went live. Retrospective data collection began in July 2010 for fentanyl patches to ensure regulatory and hospital policy compliance. At this point, the outpatient process for implementation of selected BBW medications began as outlined below.

1. The EHR Alerts Workgroup reviewed and approved the list of interventions.
2. EHR pharmacy analysts built changes into EHR and tested them.
3. Reports on the effectiveness of select medications were reported back to P&T to assess compliance and further refine workflow.

BBW medications prescribed to outpatients have not been fully configured within the EHR, resulting in the potential for use outside the criteria specified by the FDA. Starting in February 2011, FDA BBW hyperlinks were updated for both the inpatient and outpatient setting using information from the First Databank medication load list. The first outpatient version of the BBW to be configured in the EHR was dronedarone, which served as the prototype for the outpatient approval process. Between August 2011 and February 2012, multiple medication profiles were changed in the outpatient setting to incorporate their respective BBWs into the EHR. The clinical monitoring list was updated to ensure reports were accurate and included needed BBW medications and labs display at order entry; the project was completed and moved to the routine maintenance phase. This project has increased patient and health care provider awareness of BBW medications; the ability to track these medications; and understanding of the actions providers take, thereby identifying the need for additional workflow changes, education, and/or improvement. The project also helped ensure regulatory compliance and potentially avoid institutional exposure to costly litigation. A total of 1,036 individual medication records were configured during the outpatient project, which created a significant time demand on meeting deadlines and completing the project. Multiple people were pulled off other projects to complete the project on time. Considerable time was spent developing the thought process and the decision support behind differentiating or standardizing medication builds with similar warnings. Audits were established to ensure compliance with the processes implemented, but frequently there was a lack of comparison. Determining the most important warnings and best build for implementation had to be balanced with protections from alert fatigue.

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

Category 2: Conduct Medication Management

Improvement Milestone: Milestone 4.6: Smart infusion pumps are implemented for remaining 25% of infusions (PCA, epidural, and syringe pumps).

(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 4.6: 98% of all intravenous infusions administered via smart pumps.

In 2008, the UC Davis Medical Center made the decision to investigate alternative options for infusion pumps, patient-controlled analgesia (PCA) pumps, patient-controlled epidural (PCEA) pumps, and syringe pumps. The infusion pumps were the first to be addressed secondary to the FDA recall of the Baxter Colleague general-purpose infusion pumps, which were in use at the time. The next pumps to be reviewed by the multidisciplinary research and development team were the epidural pumps, with the goal of providing greater satisfaction to our obstetrics patients, allowing them the ability to control their epidural anesthesia. The CADD Solis PCEA pumps went live on November 10, 2010. About a year later, the CADD Solis PCA pumps went live on October 25, 2011, secondary to manufacturer discontinuation of the existing pumps. The initiation of smart pumps for PCAs was a milestone for DY-6. In DY-7, a two-step training process was initiated for PCA pumps prior to the go-live date of February 29, 2012. The first step included a mandatory online training that was required for entrance to the hands-on training. During the first week of using the new pumps, MedFusion was available via telephone 24 hours a day for the first seven days for support, which proved to be a critical contribution in resolving trouble-shooting. These new smart pumps have provided several benefits. The smart pump capabilities, specifically the drug library, have reduced medication errors. We are now monitoring the frequency of overriding the smart pump mode. Another benefit of the new pumps is the wireless capabilities. This allows the drug library to be uploaded remotely to facilitate maintenance. Also, several quality assurance reports are available remotely via the wireless system. These reports allow us to analyze and address any systems errors that might otherwise go unnoticed. Review of the drug library posed several challenges, such as ensuring that the concentrations chosen for the pump matched the concentrations in the electronic health record and the medication label and confirming that all necessary medications were included in the library. After developing the library, it was comprehensively tested. Through this process, we learned that thorough testing of the library is a time-intensive but necessary step that should not be taken for granted. Overall, the process of implementing new pumps has been arduous; however, we have noted numerous benefits such as decreased errors, improved patient satisfaction, and increased efficiency due to wireless technology.

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

Improvement Milestone: Milestone 4.7: Planning is completed for full implementation of bedside barcode scanning.

(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 4.7: Schedule completed and resources secured for full implementation.

In October of 2010, the UC Davis Medical Center (UCDMC) launched a pilot of barcode medication administration (BCMA) in an adult intensive care unit (Tower 7 MICU). The current Barcode Scanning Project Team gathered data from the pilot experience and developed a plan to establish hospital-wide electronic verification of the five medication rights – right patient, right medication, right dose, right route, and right time. HIMSS Stage 7 requires BCMA to be utilized on all inpatient hospital units. Since July 2011, extensive work has been done to ensure that the Medical Center's information technology (IT) infrastructure is capable of supporting barcode medication administration, including Epic (EHR vendor) mobile hardware device certification, Pyxis medication cabinet profiling, installation of servers, wireless network testing, purchase of devices and ancillary equipment (such as specialized power strips to charge the mobile computers), and the hiring of additional staff (three pharmacists and a nurse analyst). Significant work was done to assess and optimize physician and nursing workflows, automated medication cabinet (Pyxis) drug inventories, pharmacy staffing, and software interfaces. UCDMC pharmacy staff has assessed the status on bar codes on medication doses and ensured all medications ordered from suppliers have bar codes on doses, when possible. Technology is being acquired to create and place bar code labels locally when needed to address locally prepared medications or when pharmaceutical vendors have not included bar codes. To support the deployment and ongoing use of BCMA, IT, PO&M, and nursing staff have done an extensive review of the hospital care unit environments to ensure they are ready to support this technology; over 55 patient care areas were surveyed by PO&M, Facilities, Patient Care Services, Perioperative Services, Emergency Services, and IT to assess technology and power readiness for BCMA. A number of technology investments and deployments have been completed that were required for the project. The wireless network and associated network equipment was upgraded to support BCMA; 88 new network switches and 377 wireless access points were installed costing about $2 million dollars. The network upgrades improve wireless network coverage, capacity, and network speed. Additional work to upgrade the network backbone is in process. Over 650 mobile handheld computers (Honeywell) have been acquired, tested, and set up for use by registered nurses. These devices have been designed, and certified by the UCDMC's EHR vendor (Epic Systems Corporation) to support BCMA. They run the local software to support BCMA and have built-in bar code readers. Specialized hardware monitoring equipment (Mobi Control) has been deployment to IT staff to monitor and manage mobile computers. Specialized training of IT staff on the new BCMA clinical software and associated hardware has also been conducted. This project is preparing for extensive training of registered nurses who work in the UCDMC inpatient care units in the first quarter of DY-8.

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

Category 2: Conduct Medication Management

Achievement Value	1.00

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

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: The University of California, Davis Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/26/2012

REPORTING ON THIS PROJECT: * Yes

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: * $ 5,048,750.00

Incentive Funding Already Received in DY: * $ 5,048,750.00

Process Milestone: Milestone 3.2: Expand ED case management to seven days per week (infrastructure-process measure).
(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 3.2: Case management staff expanded to 4 FTE assigned to ED, at least 10 hours per day, with coverage weekends and holidays.

We have expanded case management staff to four full-time equivalents assigned to the Emergency Department (ED), with coverage provided at least 10 hours per day, including weekends and holidays. This metric was met effective May 2, 2011, with the placement of the fourth clinical case manager in the ED. Between July 1, 2011 – June 30, 2012, 4,809 interventions were performed for 1,731 patients. In the first six months of DY-7, 838 patients were assessed with 2,380 interventions, and in the second half of DY-7, 893 patients were assessed with 2,429 interventions. Interventions included the following patient care activities: 1) patient assessment, 2) referral/placement in skilled nursing facility, 3) referral home health/hospice, 4) care conference with interdisciplinary staff, 5) coordination of care/medical follow-up, 6) referral/placement of patients on 5150 holds to psychiatric facilities, 7) patient/family education, 8) coordination of outpatient clinic appointment, 9) referral to housing/shelter, 10) transportation, 11) coordination of funding resources, 12) assistance regarding medications, 13) transfers to acute facilities when appropriate, 14) obtaining durable medical equipment, 15) assistance in establishing a primary care provider, 16) referral to assisted living/board and care, and 17) providing community resources.

With the expansion of case management service in the ED, we have found an opportunity to collaborate with community providers in an effort to improve services for our patients. Over the last year, the ED case managers have provided significant assistance in obtaining placement in the community for patients who have been placed on involuntary psychiatric holds but do not need admission to the acute hospital setting. With a diminishing number of beds in psychiatric facilities in our community, efforts to place these patients have led to a collaborative project between the ED clinical case managers, the Psychiatry Department, the Department of Clinical Social Services, and our local county mental health facility, the Sacramento Mental Health Treatment Center (SMHTC). This project includes daily rounds in the ED between the psychiatry team and case managers. As a part of the project, there is now an assigned liaison from the SMHTC available to the ED case managers and psychiatry to help facilitate the placement of patients on psychiatric holds. As a result, there has been an overall decrease in wait time in the ED for patients who require inpatient psychiatric placement at discharge from the ED.

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

Achievement Value: 1.00

Process Milestone: Milestone 3.3: Plan the construction of a tethered registry to EHR to identify and manage high risk patients (innovation and redesign-process measure).
(insert milestone)

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

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

Category 2: Implement/Expand Care Transitions Programs

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 3.3: Plan completed with IS and EHR.

The Intensive Case Management Registry Team was convened to address goals of the registry. Membership includes representatives from Clinical Case Management, Knowledge Management (IT), and Lean Six Sigma. The group has established a project charter and a process map for identifying patients eligible for intensive case management. Additionally, the departments of Clinical Case Management and Information Services have developed a layered plan to identify and track patients who are chronic health care consumers of the ED at the UC Davis Medical Center (UCDMC). Ultimately, the tethered registry will provide the collection of significant patient data from the electronic health record (EHR) including clinical information, demographics, and social history. It will also facilitate the identification of chronic disease conditions that can potentially be managed by providers in other parts of the Medical Center (Project 1.3). Once a patient is screened and placed into the intensive case management (ICM) registry, patients will be followed for ICM services whenever they present to the ED and/or are admitted to the inpatient setting. However, the implementation of the tethered registry is not expected until late in 2012. Pending the development of the tethered registry, the Department of Clinical Case Management has access to two EHR reports to identify patients who may be eligible for ICM services: 1) patients who have had four or more ED visits during the last six months and 2) patients who have had an ED visit resulting in admission three or more times during the last 12 months. As these reports have identified a very large number of patients, screening criteria need to be established to identify who can benefit most from ICM services. Our goal for DY-8 is to register more than 50% of all ED case managed patients and high-risk patients admitted from the ED to the Medical Center. The success of this project depends on three key factors: 1) the development of screening criteria to identify those patients who can benefit most from ICM services; 2) the implementation of a plan to enable UCDMC staff to identify patients in the EHR who are registered in the ICM Program; and 3) the deployment of a tethered registry in the EHR.

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

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

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

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: The University of California, Davis Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/26/2012

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: * $ 3,378,375.00

Incentive Funding Already Received in DY: * $ 3,378,375.00

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

Metric 11.1: Plan for implementation of CG-CAHPS completed.

The UC Davis Medical Center (UCDMC) appointed the Patient Experience Officer's Team in DY-6 in anticipation of the extensive planning necessary to achieve the implementation of CG-CAHPS in DY-8. This team includes members from Senior Leadership, Clinical Operations, Marketing/Public Affairs, Patient Relations, and Performance Improvement. The charge of the team is to work with the Safety Net Institute (SNI) to provide feedback on the California-modified proposal, its sampling methodology, and data collection timelines for public hospital systems. Finalization of the CG-CAHPS implementation plan, including planning and staging the survey, executing contracts, and incorporating the CG-CAHPS core patient experience questions, was completed in October 2011 when Professional Research Consultants, Inc. (PRC) went live with the survey. Efforts were made to work with Marketing to ensure the core CG-CAHPS-approved (California) questions were appropriately integrated into the PRC surveys on schedule and in compliance with sampling constraints. Marketing representatives also joined the CG-CAHPS SNI meetings in Oakland to provide perspective on AHRQ requirements for CG-CAHPS. For example, administration of CG-CAHPS can involve a "12-Month" version (asking patients to rate their experience over the course of the past 12 months). For DSRIP, SNI has chosen to endorse the "Visit" version, which focuses primarily on the patient's most recent visit. Between October 2011 and June 2012, 225 patients were surveyed from family practice, general medicine, and the Primary Care Network sites (combined) to acquire a total sample of 675. In a standard 12-month period, 300 patients are to be sampled from each site. Although planning and implementation have gone well, there is concern that the sample size may not reflect accurate scores for public reporting and that sample size by provider is too low to make real improvements in patient experience. Lastly, UCDMC is considering switching survey vendors to Press Ganey in 2013 so that its survey procedures are in alignment with other University of California medical center campuses.

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 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

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: The University of California, Davis Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/26/2012

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:	*	$ 3,378,376.00
Incentive Funding Already Received in DY:	*	$ 1,689,188.50

Report results of the Diabetes, short-term complications measure to the State *(DY7-10)*

Data Collection Source	*	Electronic medical record (EMR)
Numerator	*	15.0
Denominator	*	8,787.0
Rate		0.2

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):

Metric 12.1: Results of Diabetes, short-term complications measure reported to the State.

Introduction: Because many of the UC Davis Medical Center (UCDMC) DSRIP goals required Information Technology (IT) support for outcomes reporting, an IT team was convened to help project owners plan their semi-annual and annual DSRIP reports. The IT business analyst met with DSRIP project owners and confirmed expectations for IT support for each DY-7 goal. Some projects required support solely through the development of baseline reports while other projects required a specialist to assist in the development of new electronic health record (EHR) workflows so that data could be captured for surveillance and reporting needs. The development of new workflows is led by the Knowledge Management Team, which consists of clinical and technical analysts, database programmers, and report writers. The Knowledge Team is responsible for designing clinical data capture in the EHR, collecting data, and coordinating delivery to the Tethered Meta Registry with the IT Research Team. Category 3 data validation is provided by a multi-disciplinary workgroup including the UCDMC chief medical officer, medical directors representing the EHR and chronic disease management, an inpatient coding and clinical documentation specialist, two DSRIP project managers, an IT report analyst, and the Knowledge Management supervisor. Throughout DY-7, the workgroup reviewed reporting requirements, confirmed expectations, and selected appropriate data sources when data existed in more than one system. After the requirements were confirmed, the IT report analyst applied the accepted logic to produce reports. The workgroup was reconvened, and the reports were reviewed and validated. Validation was started at the workgroup level and then delegated to specific members to perform random chart audits. The primary challenge encountered in the DY-7 Category 3 reporting was responding to frequent changes in reporting requirements communicated by the Safety Net Institute. Changes included new exclusion criteria as well as shifts in the expected reporting periods. These changes came throughout the DY-7 period and caused significant rework. The most concerning challenge involved the new exclusions. As written, some of the exclusions could not be incorporated in reporting logic because they could not be mapped to a codified data element.

Analysis of this metric was performed by the UCDMC's Knowledge Management Team. The denominator is the number of diabetes patients (age 15-75) with two or more primary care visits in FY 2010/2011: 8,787. The numerator is number the of UCDMC inpatient discharges with principal diagnosis ICD-9 codes indicating diabetes with short term complications within the denominator population during FY 2011/2012 (ie, DY-7): 15.

Achievement	Yes
Achievement Value	1.00

Report results of the Uncontrolled Diabetes measure to the State *(DY7-10)*

Category 3: Care Coordination *(required)*

Data Collection Source	*	Electronic medical record (EMR)
Numerator	*	3.0
Denominator	*	8,787.0
Rate		0.0

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):

Metric 12.2: Results of Uncontrolled Diabetes measure reported to the State.

Introduction: Because many of the UC Davis Medical Center (UCDMC) DSRIP goals required Information Technology (IT) support for outcomes reporting, an IT team was convened to help project owners plan their semi-annual and annual DSRIP reports. The IT business analyst met with DSRIP project owners and confirmed expectations for IT support for each DY-7 goal. Some projects required support solely through the development of baseline reports while other projects required a specialist to assist in the development of new electronic health record (EHR) workflows so that data could be captured for surveillance and reporting needs. The development of new workflows is led by the Knowledge Management Team, which consists of clinical and technical analysts, database programmers, and report writers. The Knowledge Team is responsible for designing clinical data capture in the EHR, collecting data, and coordinating delivery to the Tethered Meta Registry with the IT Research Team. Category 3 data validation is provided by a multi-disciplinary workgroup including the UCDMC chief medical officer, medical directors representing the EHR and chronic disease management, an inpatient coding and clinical documentation specialist, two DSRIP project managers, an IT report analyst, and the Knowledge Management supervisor. Throughout DY-7, the workgroup reviewed reporting requirements, confirmed expectations, and selected appropriate data sources when data existed in more than one system. After the requirements were confirmed, the IT report analyst applied the accepted logic to produce reports. The workgroup was reconvened, and the reports were reviewed and validated. Validation was started at the workgroup level and then delegated to specific members to perform random chart audits. The primary challenge encountered in the DY-7 Category 3 reporting was responding to frequent changes in reporting requirements communicated by the Safety Net Institute. Changes included new exclusion criteria as well as shifts in the expected reporting periods. These changes came throughout the DY-7 period and caused significant rework. The most concerning challenge involved the new exclusions. As written, some of the exclusions could not be incorporated in reporting logic because they could not be mapped to a codified data element.

Analysis of this metric was performed by UCDMC's Knowledge Management Team. The denominator is the number of diabetes patients (age 15-75) with two or more primary care visits in FY 2010/2011: 8,787. The numerator is the number of UCDMC inpatient discharges with principal diagnosis ICD-9 codes indicating uncontrolled diabetes within the denominator population during FY 2011/2012 (ie, DY-7): 3.

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: The University of California, Davis Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/26/2012

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

Preventive Health (required)

DY Total Computable Incentive Amount:	*	$ 3,378,376.00
Incentive Funding Already Received in DY:	*	$ 1,689,188.50

Report results of the Mammography Screening for Breast Cancer measure to the State *(DY7-10)*

Data Collection Source	*	Electronic medical record (EMR)
Numerator	*	10,919.0
Denominator	*	16,509.0
Rate		66.1

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):

Metric 13.1: Results of Mammography Screening for Breast Cancer measure reported to the State.

Introduction: Because many of the UC Davis Medical Center (UCDMC) DSRIP goals required Information Technology (IT) support for outcomes reporting, an IT team was convened to help project owners plan their semi-annual and annual DSRIP reports. The IT business analyst met with DSRIP project owners and confirmed expectations for IT support for each DY-7 goal. Some projects required support solely through the development of baseline reports while other projects required a specialist to assist in the development of new electronic health record (EHR) workflows so that data could be captured for surveillance and reporting needs. The development of new workflows is led by the Knowledge Management Team, which consists of clinical and technical analysts, database programmers, and report writers. The Knowledge Team is responsible for designing clinical data capture in the EHR, collecting data, and coordinating delivery to the Tethered Meta Registry with the IT Research Team. Category 3 data validation is provided by a multi-disciplinary workgroup including the UCDMC chief medical officer, medical directors representing the EHR and chronic disease management, an inpatient coding and clinical documentation specialist, two DSRIP project managers, an IT report analyst, and the Knowledge Management supervisor. Throughout DY-7, the workgroup reviewed reporting requirements, confirmed expectations, and selected appropriate data sources when data existed in more than one system. After the requirements were confirmed, the IT report analyst applied the accepted logic to produce reports. The workgroup was reconvened, and the reports were reviewed and validated. Validation was started at the workgroup level and then delegated to specific members to perform random chart audits. The primary challenge encountered in the DY-7 Category 3 reporting was responding to frequent changes in reporting requirements communicated by the Safety Net Institute. Changes included new exclusion criteria as well as shifts in the expected reporting periods. These changes came throughout the DY-7 period and caused significant rework. The most concerning challenge involved the new exclusions. As written, some of the exclusions could not be incorporated in reporting logic because they could not be mapped to a codified data element.

Analysis of this metric was performed by UCDMC's Knowledge Management Team. The denominator is the number of female patients age 50-74 with two or more primary care visits in FY 2010/2011: 16,509. The numerator is the number of patients with a complete order status for procedure codes indicating bilateral, unilateral-left, unilateral-right, mammography screening, and US breast unilateral/bilateral mammography screening within the denominator population during a 24-month period ending June 30, 2012: 10,919. Our analysts were unable to provide the following electronic exclusions: enrolled in a Veterans Health Administration (VHA) or community-based hospice program and history of gender alteration.

Achievement	Yes
Achievement Value	1.00

Category 3: Preventive Health *(required)*

Reports results of the Influenza Immunization measure to the State *(DY7-10)*

Data Collection Source	*	Electronic medical record (EMR)
Numerator	*	17,057.0
Denominator	*	37,322.0
Rate		45.7

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):

Metric 13.2: Results of Influenza Immunization measure reported to the State.

Introduction: Because many of the UC Davis Medical Center (UCDMC) DSRIP goals required Information Technology (IT) support for outcomes reporting, an IT team was convened to help project owners plan their semi-annual and annual DSRIP reports. The IT business analyst met with DSRIP project owners and confirmed expectations for IT support for each DY-7 goal. Some projects required support solely through the development of baseline reports while other projects required a specialist to assist in the development of new electronic health record (EHR) workflows so that data could be captured for surveillance and reporting needs. The development of new workflows is led by the Knowledge Management Team, which consists of clinical and technical analysts, database programmers, and report writers. The Knowledge Team is responsible for designing clinical data capture in the EHR, collecting data, and coordinating delivery to the Tethered Meta Registry with the IT Research Team. Category 3 data validation is provided by a multi-disciplinary workgroup including the UCDMC chief medical officer, medical directors representing the EHR and chronic disease management, an inpatient coding and clinical documentation specialist, two DSRIP project managers, an IT report analyst, and the Knowledge Management supervisor. Throughout DY-7, the workgroup reviewed reporting requirements, confirmed expectations, and selected appropriate data sources when data existed in more than one system. After the requirements were confirmed, the IT report analyst applied the accepted logic to produce reports. The workgroup was reconvened, and the reports were reviewed and validated. Validation was started at the workgroup level and then delegated to specific members to perform random chart audits. The primary challenge encountered in the DY-7 Category 3 reporting was responding to frequent changes in reporting requirements communicated by the Safety Net Institute. Changes included new exclusion criteria as well as shifts in the expected reporting periods. These changes came throughout the DY-7 period and caused significant rework. The most concerning challenge involved the new exclusions. As written, some of the exclusions could not be incorporated in reporting logic because they could not be mapped to a codified data element.

Analysis of this metric was performed by UCDMC's Knowledge Management Team. The denominator is the number of patients age 50 or older with two or more primary care visits in FY 2010/2011: 37,322. The numerator is the number of encounters where status is given for "influenza vaccine" during the period September 1, 2011 – February 29, 2012: 17,057. When a patient reported receiving an influenza immunization elsewhere (eg, Sam's Club, Walgreens, etc.), this was reported in the numerator.

Achievement	Yes
Achievement Value	1.00

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

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: The University of California, Davis Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/26/2012

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:	*	$ 3,378,376.00
Incentive Funding Already Received in DY:	*	$ 1,689,188.50

Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State *(DY7-10)*

Data Collection Source	*	Electronic medical record (EMR)
Numerator	*	4,359.0
Denominator	*	8,787.0
Rate		49.6

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):

Metric 14.1: Results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (< 100 mg/dl) measure reported to the State.

Introduction: Because many of the UC Davis Medical Center (UCDMC) DSRIP goals required Information Technology (IT) support for outcomes reporting, an IT team was convened to help project owners plan their semi-annual and annual DSRIP reports. The IT business analyst met with DSRIP project owners and confirmed expectations for IT support for each DY-7 goal. Some projects required support solely through the development of baseline reports while other projects required a specialist to assist in the development of new electronic health record (EHR) workflows so that data could be captured for surveillance and reporting needs. The development of new workflows is led by the Knowledge Management Team, which consists of clinical and technical analysts, database programmers, and report writers. The Knowledge Team is responsible for designing clinical data capture in the EHR, collecting data, and coordinating delivery to the Tethered Meta Registry with the IT Research Team. Category 3 data validation is provided by a multi-disciplinary workgroup including the UCDMC chief medical officer, medical directors representing the EHR and chronic disease management, an inpatient coding and clinical documentation specialist, two DSRIP project managers, an IT report analyst, and the Knowledge Management supervisor. Throughout DY-7, the workgroup reviewed reporting requirements, confirmed expectations, and selected appropriate data sources when data existed in more than one system. After the requirements were confirmed, the IT report analyst applied the accepted logic to produce reports. The workgroup was reconvened, and the reports were reviewed and validated. Validation was started at the workgroup level and then delegated to specific members to perform random chart audits. The primary challenge encountered in the DY-7 Category 3 reporting was responding to frequent changes in reporting requirements communicated by the Safety Net Institute. Changes included new exclusion criteria as well as shifts in the expected reporting periods. These changes came throughout the DY-7 period and caused significant rework. The most concerning challenge involved the new exclusions. As written, some of the exclusions could not be incorporated in reporting logic because they could not be mapped to a codified data element.

Analysis of this metric was performed by UCDMC's Knowledge Management Team. The denominator is the number of diabetes patients (age 18-75) with two or more primary care visits in FY 2010/2011: 8,787. The numerator is the number of diabetes patients with LDL-C results of less than 100 mg/dl between July 1, 2011 – June 30, 2012 (ie, DY-7): 4,359. (Note: LDL direct supersedes LDL calculation if both are done at the same time.)

Achievement	Yes
Achievement Value	1.00

Category 3: At-Risk Populations *(required)*

Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<8%) measure to the State *(DY7-10)*

Data Collection Source	*	Electronic medical record (EMR)
Numerator	*	5,584.0
Denominator	*	8,787.0
Rate		63.5

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):

Metric 14.2: Results of Diabetes Mellitus: Hemoglobin A1c Control (<8%) measure reported to the State.

Introduction: Because many of the UC Davis Medical Center (UCDMC) DSRIP goals required Information Technology (IT) support for outcomes reporting, an IT team was convened to help project owners plan their semi-annual and annual DSRIP reports. The IT business analyst met with DSRIP project owners and confirmed expectations for IT support for each DY-7 goal. Some projects required support solely through the development of baseline reports while other projects required a specialist to assist in the development of new electronic health record (EHR) workflows so that data could be captured for surveillance and reporting needs. The development of new workflows is led by the Knowledge Management Team, which consists of clinical and technical analysts, database programmers, and report writers. The Knowledge Team is responsible for designing clinical data capture in the EHR, collecting data, and coordinating delivery to the Tethered Meta Registry with the IT Research Team. Category 3 data validation is provided by a multi-disciplinary workgroup including the UCDMC chief medical officer, medical directors representing the EHR and chronic disease management, an inpatient coding and clinical documentation specialist, two DSRIP project managers, an IT report analyst, and the Knowledge Management supervisor. Throughout DY-7, the workgroup reviewed reporting requirements, confirmed expectations, and selected appropriate data sources when data existed in more than one system. After the requirements were confirmed, the IT report analyst applied the accepted logic to produce reports. The workgroup was reconvened, and the reports were reviewed and validated. Validation was started at the workgroup level and then delegated to specific members to perform random chart audits. The primary challenge encountered in the DY-7 Category 3 reporting was responding to frequent changes in reporting requirements communicated by the Safety Net Institute. Changes included new exclusion criteria as well as shifts in the expected reporting periods. These changes came throughout the DY-7 period and caused significant rework. The most concerning challenge involved the new exclusions. As written, some of the exclusions could not be incorporated in reporting logic because they could not be mapped to a codified data element.

Analysis of this metric was performed by UCDMC's Knowledge Management Team. The denominator is diabetes patients age 18-75 with two or more primary care visits in FY 2010/2011: 8,787. The numerator is the number of diabetes patients with a hemoglobin A1c result of less than 8% during the period July 1, 2011 – June 30, 2012: 5,584. Previously, this metric was reported as hemoglobin A1c less than 9%.

Achievement	Yes
Achievement Value	1.00

Category 3: At-Risk Populations *(required)*

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)*

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: The University of California, Davis 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:	*	$ 2,329,250.00
Incentive Funding Already Received in DY:	*	$ 1,941,041.67

Compliance with Sepsis Resuscitation bundle (%)

Numerator	*	279
Denominator	*	626
% Compliance		0.45

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):

Metric 7.6: Sepsis Resuscitation Bundle results reported to the State.

We had a sepsis resuscitation bundle rate for DY-7 (July 1, 2011 – June 30, 2012) of 44.6% (279 cases of bundle compliance out of 626 cases of severe sepsis or septic shock). In the first half of DY-7 (July 1, 2011 – December 31, 2011), the bundle resuscitation rate was 43.8% (110 cases of bundle compliance out of 251 cases of severe sepsis or septic shock). In the second half of DY-7, the bundle resuscitation rate was 45.1% (169 cases of bundle compliance out of 375 cases of severe sepsis or septic shock). This reflects a 3.0% improvement between the two six month periods of DY-7. The rate we reported in the first semi-annual DY-7 report (July 1, 2011 – December 31, 2011) was 28.2% (81 cases of bundle compliance out of 287 cases of severe sepsis or septic shock). Since then, we have validated the clinical data collected in the sepsis registry and feel that the numbers reported above more accurately reflect DY-7 performance.

DY Target (from the DPH system plan, if appropriate)	*	
% Achievement of Target		N/A
Achievement Value		1.00

Optional Milestone: Milestone 7.4: Develop and implement Best Practice Alerts within the UCDMC EHR for early sepsis recognition.
(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 7.4: Best Practice Alerts developed and implemented within the UCDMC EHR for early Sepsis recognition (targeting all adult patients in our emergency department, acute care, and critical care units).

This project receives guidance and oversight from the Sepsis Improvement Committee, which includes representatives from medicine, nursing, pharmacy, laboratory, infection control, and information technology as well as the ICU, ACU, Emergency Department, and procedural areas. The charge of the committee is to develop infrastructure and processes to

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

improve the early recognition and treatment of severe sepsis and septic shock by leveraging the electronic health record (EHR) in an effort to reduce mortality in this patient population. Preliminary work on this project began in October 2010, when the UC Davis Medical Center partnered with Betty and Gordon Moore Foundation and SNI to learn and share best practices related to improving severe sepsis and septic shock detection and management. In March 2011, the targeted patient population was defined as those meeting systemic inflammatory response syndrome (SIRS) criteria with signs/symptoms of infection and treatment bundle elements developed based on Institute for Healthcare Improvement guidelines and other published data. In May 2011, the EHR "Best Practice Alerts" (BPAs) and sepsis order sets (ie, screening, treatment, and reassessment) were built, validated, and tested within the Epic EHR (see Project 6.3 for a complete description of BPAs). Subsequent to this, screening and treatment protocols and policies were developed. In June 2011, e-Learning was presented to 100% of nurses and 58% of physicians, thereby allowing the ordersets to go live across all units/services in July 2011. Since then, data mining infrastructure has been developed using Epic tools and registry technology. Ongoing QI projects are being implemented to enhance education (eg, new nursing orientation, physician orientation, just-in-time unit champion coaching, etc.) and promote process improvement (eg, adoption of sepsis bundle). It is important to note that this project was viewed as having significant clinical merit across disciplines and units and that meaningful compliance with our bundle elements (29%) was achieved with a 24% decrease in severe sepsis/septic shock mortality (2009 vs. 2011). Nonetheless, significant challenges were encountered. The lack of data reporting infrastructure/platforms in Epic served as a barrier that is currently being resolved through the use of a "Registry" platform that will allow compliance reporting by unit/service to help facilitate QI. Additionally, we experienced staff disengagement due to both too much and too little information being provided and are combating this by managing the message and providing better feedback with relevant data. We continue to share best practice with other institutions and have negotiated standardization of data collection and information obtained/shared with other hospitals and collaboratives. Issues that may affect the success of the project in the future are the availability of resources to sustain interest; analytic expertise to process and advance required enhancements/modification to the program (eg, increase specificity of alert); and additional support to advance bundle compliance and sustain mortality reduction.

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

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

Optional Milestone: Milestone 7.5: Report at least 6 months of data collection on sepsis resuscitation bundle to SNI for purposes of establishing a baseline and setting benchmarks.

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	279.00
Denominator (if absolute number, enter "1")	*	626.00
Achievement		0.45
If "yes/no" as to whether the milestone has been achieved, 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 7.5: At least 6 months of data collection on Sepsis Resuscitation Bundle reported to SNI for purposes of establishing the baseline and setting benchmarks.

We had a sepsis resuscitation bundle rate for DY-7 (July 1, 2011 – June 30, 2012) of 44.6% (279 cases of bundle compliance out of 626 cases of severe sepsis or septic shock) and would like to use this rate for our sepsis resuscitation bundle baseline considering current cohort and bundle measure definitions. In the first half of DY-7 (July 1, 2011 – December 31, 2011), the bundle resuscitation rate was 43.8% (110 cases of bundle compliance out of 251 cases of severe sepsis or septic shock). In the second half of DY-7, the bundle resuscitation rate was 45.1% (169 cases of bundle compliance out of 375 cases of severe sepsis or septic shock). This reflects a 3.0% improvement between the two six month periods of DY-7. The rate we reported in the first semi-annual DY-7 report (July 1, 2011 – December 31, 2011) was 28.2% (81 cases of bundle compliance out of 287 cases of severe sepsis or septic shock). Since then, we have validated the clinical data collected in the sepsis registry and feel that the numbers reported above more accurately reflect DY-7 performance and should be used as a baseline for measuring future improvement.

If severe sepsis or septic shock patient inclusion/exclusion criteria or bundle compliance measure criteria are modified, the baseline will require recalculation. Because we are proposing a baseline after the start of our sepsis improvement project, we will recommend sustained performance in this range over the next three years. Intensive work on individual measures may lead to some added improvement.

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

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:	*	

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

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

Achievement Value

Category 4: Severe Sepsis Detection and Management *(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: Severe Sepsis Detection and Management *(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

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: The University of California, Davis Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/26/2012

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
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Central Line Associated Blood Stream Infection

DY Total Computable Incentive Amount:	*	$ 1,905,750.00
Incentive Funding Already Received in DY:	*	$ 1,588,125.00

Compliance with Central Line Insertion Practices (CLIP) (%)

Numerator	*	2,042.00
Denominator	*	2,096.00
% Compliance		0.97

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):

Metric 8.4: CLIP results reported to the State.

We had a CLIP compliance rate for DY-7 (July 1, 2011 – June 30, 2012) of 97.4% (2,042 documented bundle compliant insertions out of 2,096 central line insertions) per our NHSN data. In the first half of DY-7 (July 1, 2011 – December 31, 2011), our CLIP compliance rate was 98.5% (1,043 documented bundle compliant insertions out of 1,059 central line insertions). In the second half of DY-7 (January 1, 2012 – June 30, 2012), our CLIP compliance rate was 96.3% (999 documented bundle compliant insertions out of 1,037 central line insertions). This is roughly a 2% decrease in compliance between the first and second half of DY-7, but we have systems in place to monitor staff performance and ensure compliance does not slip further. We had originally proposed monitoring CLIP compliance through our own internal data collection processes, which were used in the first semi-annual DY-7 report when we reported a CLIP compliance rate of 78.0% (1,074 documented bundle compliant insertions out of 1,377 central line insertions). To ensure comparability between our CLIP performance and those of other California DPHs, we are planning to use NHSN data for future CLIP reporting.

DY Target (from the DPH system plan)	*	
% Achievement of Target		N/A
Achievement Value		1.00

Optional Milestone: Milestone 8.2: Report at least 6 months of data on CLIP to SNI for the purposes of establishing a baseline and setting benchmarks.
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	2,042.00
Denominator (if absolute number, enter "1")	*	2,096.00
Achievement		0.97

If "yes/no" as to whether the milestone has been achieved, 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 8.2: At least 6 months of data on CLIP reported to SNI for purposes of establishing the baseline and setting benchmarks.

This project is being led by Karen Mondino, RN, MSN, manager of the SICU/CTICU, with support from the IV resource committee, the Bloodstream Infection (BSI) Lean Six Sigma project, Infection Prevention (IP), and the ICU committee. These groups meet on a monthly basis to discuss central line bundles, documentation of central line necessity on a daily

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

basis by physicians/nurses, hand hygiene, and decreasing BSI rates. Patients are now followed through their hospital stay in the acute care/ICU settings. Blood culture results are monitored on a daily basis by IP. A dashboard is maintained for all to access so that managers can follow cultures that meet National Health Care Safety Network (NHSN) criteria. Since fall 2006, rates have improved from 6.2 to 1.9 per 1,000 central line days. Things that have been done to reduce CLABSI include: 1) development of central line kits; 2) use of the chlorhexidene (CHG) baths; 3) dissemination of CLIP forms to all areas of the hospital; 4) central line procedure check lists; 5) extensive blood culture education; 6) utilizing swab caps; 7) changing from Rymed to Clave connectors; and 8) a hand hygiene project started within the hospital setting. Education in regard to blood cultures shows a decrease in contamination from 7% to 3.5%. The documentation of infection control data and CLIP forms has been ongoing for many years. An ongoing obstacle has been documenting the daily necessity of central lines, for the physician group, within the electronic health record (EHR). The process took a year (and an upgrade to the Epic system) to find a simplified documentation process where reports could be run on a daily basis to monitor compliance. Within a short period of time, we achieved 78% compliance. Education has been provided through e-mail and flyers with continued follow up from Chief Medical Officer Allan Siefkin, MD, and Karen Mondino, RN. Our goal is to continue to provide education to physicians at all levels in regard to documentation until we achieve 100% compliance. The completion of the CLIP form has been an ongoing challenge. Originally, it was presented in a paper format that made tracking compliance difficult. The EHR version currently being used has been reformatted to comply with new CDC requirements. We currently have compliance rates of more than 90% across different services. Compliance reports are reviewed in the ICU committee, and physicians with documented non-compliance are addressed through their medical directors.

We had a CLIP compliance rate for DY-7 (July 1, 2011 – June 30, 2012) of 97.4% (2,042 documented bundle compliant insertions out of 2,096 central line insertions) per our NHSN data and would like to submit this rate for our baseline. In the first half of DY-7 (July 1, 2011 – December 31, 2011), our CLIP compliance rate was 98.5% (1,043 documented bundle compliant insertions out of 1,059 central line insertions). In the second half of DY-7 (January 1, 2012 – June 30, 2012), our CLIP compliance rate was 96.3% (999 documented bundle compliant insertions out of 1,037 central line insertions). This is roughly a 2% decrease in compliance between the first and second half of DY-7, but we have systems in place to monitor staff performance and ensure compliance does not slip further. We had originally proposed monitoring CLIP compliance through our own internal data collection processes, which were used in the first semi-annual DY-7 report when we reported a CLIP compliance rate of 78.0% (1,074 documented bundle compliant insertions out of 1,377 central line insertions). To ensure comparability between our CLIP performance and those of other California DPHs, we are planning to use NHSN data for future CLIP reporting.

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

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

Optional Milestone: Milestone 8.3: Report at least 6 months of data collection on CLABSI to SNI for the purposes of establishing the baseline and setting benchmarks.

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	97.00
Denominator (if absolute number, enter "1")	*	59,109.00
Achievement		0.00
If "yes/no" as to whether the milestone has been achieved, 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 8.3: At least 6 months of data on CLABSI reported to SNI for purposes of establishing the baseline and setting benchmarks.

We had a CLABSI rate for DY-7 (July 1, 2011 – June 30, 2012) of 1.64 infections per 1,000 central line device days (97 infections out of 59,109 central line device days) and would like to use this rate for our CLABSI baseline. In the first half of DY-7 (July 1, 2011 – December 31, 2011), our CLABSI rate was 1.82 infections per 1,000 central line device days (54 infections out of 29,682 central line device days). In the second half of DY-7 (January 1, 2012 – June 30, 2012), our CLABSI rate was 1.46 per 1,000 central line device days (43 infections out of 29,427 central line device days). This is roughly a 19.8% improvement in CLABSI rate and attests to the significant work UC Davis Medical Center (UCDMC) has implemented to achieve CLABSI reduction. We should note that this baseline is based on a whole house infection rate per the Category 4 technical specifications.

CAPH/SNI has proposed a new definition for CLABSI that would only include intensive care unit, acute care unit, and neonatal intensive care unit bloodstream infections, with specialty care being excluded, which may go into effect in DY-8 and subsequently require a modification of the UCDMC DSRIP plan. If we use that definition, our CLABSI rate for DY-7 (July 1, 2011 – June 30, 2012) would be 1.52 infections per 1,000 central line device days (79 infections out of 52,132 central line device days). In the first half of DY-7 (July 1, 2011 – December 31, 2011), our CLABSI rate was 1.67 infections per 1,000 central line device days (44 infections out of 26,305 central line device days). In the second half of DY-7 (January 1, 2012 – June 30, 2012), our CLABSI rate was 1.36 per 1,000 central line device days (35 infections out of 25,827 central line device days). This is roughly a 18.5% improvement in CLABSI rates using the newly proposed definition.

We had originally proposed a six-month CLABSI baseline of 3.1 infections per 1,000 central line device days (88 infections out of 28,514 central line device days) for the period July – December 2010. We feel that this baseline is not close enough to the improvement period (ie, DY-8) to guide meaningful performance improvement through the remainder of the waiver program.

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

Optional Milestone: _____

(insert milestone)

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

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

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

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: The University of California, Davis Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/26/2012

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: * $ 1,905,750.00

Incentive Funding Already Received in DY: * $ 1,588,125.00

Rate of surgical site infection for Class 1 and 2 wounds (%)

Numerator * 67.00

Denominator * 3,476.00

% Infection Rate 0.02

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):

Metric 9.5: Surgical site infection rate results reported to the State.

In DY-7 (July 1, 2011 – June 30, 2012), we had a surgical site infection rate of 1.93% (67 surgical site infections out of 3,476 surgeries performed). In the first half of DY-7 (July 1, 2011 – December 30, 2011), we had a surgical site infection rate of 2.60% (42 surgical site infections out of 1,618 surgeries performed). In the second half of DY-7 (January 1, 2012 – June 30, 2012), we had a surgical site infection rate of 1.35% (25 surgical site infections out of 1,858 surgeries performed). We are following surgical site infections across 11 procedural areas (eg, colon, rectal, c-section, gastric, hernia, hysterectomy, prostate, neck, knee replacement, hip replacement, and small bowel). The interventions used to achieve this reduction are reported in Project 9.3 and have allowed us to reduce surgical site infections by 48% between the two six-month reporting periods of DY-7.

The annual DY-7 infection rate for each surgical procedure is as follows: 1) colon surgery: 3.94% (11 surgical site infections out of 279 surgeries performed); 2) rectal surgery: 5.26% (3 surgical site infections out of 57 surgeries performed); 3) c-section: 0.37% (2 surgical site infections out of 537 surgeries performed); 4) gastric surgery: 1.01% (3 surgical site infections out of 297 surgeries); 5) hernia repair: 0.59% (5 surgical site infections out of 843 surgeries); 6) hysterectomy: 1.88% (6 surgical site infections out of 320 surgeries); 7) knee replacement: 1.92% (6 surgical site infections out of 312 surgeries); 8) neck surgery: 6.45% (8 surgical site infections out of 124 surgeries); 9) prostate surgery: 3.45% (3 surgical site infections out of 87 surgeries); 10) small bowel surgery: 7.73% (17 surgical site infections out of 220 surgeries); and 11) hip replacement surgery: 0.75% (3 surgical site infections out of 400 surgeries).

DY Target (from the DPH system plan) *

% Achievement of Target N/A

Achievement Value 1.00

Optional Milestone: Milestone 9.3: Install TheraDoc software and train staff to streamline surgical site infection surveillance.

(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 9.3: TheraDoc software installed and staff trained to streamline surgical site infection surveillance.

The surgical site infection surveillance team is supported by the Infection Prevention Department, led by Marsha Koopman. The team consists of two infectious diseases physicians, two infection surveillance nurses, and an analyst. The

Category 4: Surgical Site Infection Prevention

SSI team meets weekly to discuss interventions and progress on the project. Every patient developing a post-operative infection is reviewed by the team. Assessing the infrastructure and determining the appropriate staffing levels to achieve review of 1,000 to 1,300 surgical cases monthly was accomplished in January 2011. Three additional full-time equivalents were added to the Infection Prevention Department to ensure the surgical cases were reviewed in a timely manner. TheraDoc, a gold standard data mining system, was purchased and installed in January 2011. TheraDoc allows for transfer of NHSN-required data elements into coded fields for analysis. To fully explore the capabilities of the system, we hired an analyst and two surgical site surveillance nurses to assess surgical patients post-operatively. The nurses gather the 121 data points required by NHSN. The Institute for Health Improvement (IHI) measures reported in the Surgical Care Improvement Project (SCIP) were fully implemented at the UC Davis Medical Center (UCDMC), and currently 90% to 95% performance is achieved. We are discussing antibiotic dosing based on patient weight, especially for those patients exceeding 300 pounds, and re-dosing patients when the surgical procedure is longer than four hours. A colorectal post-surgical infection reduction project was implemented with significant improvement based on findings that hypothermia causes vasoconstriction, reducing the delivery of intravenous medications, and suppresses the immune system. A noteworthy reduction for colorectal infections occurred after ensuring normothermia for colorectal surgical patients. One of the physician epidemiologists, Jennifer Brown, is currently studying post-operative methicillin-resistant Staphylococcus aureus infections (MRSA). A plan to eliminate MRSA post-operative surgical site infections was presented to the Infection Prevention Committee, approved, and is being implemented within the surgical services. The increased workload created by adding surveillance for 1,000 to 1,300 surgical site cases stalled our monthly workflow. Many steps and personnel are involved in pre-operative, post-operative, and post-discharge care of surgical patients. These factors make identifying root causes for infection and opportunities for surgical improvement difficult. We learned we were able to collect 60% of the 121 (or 79) data points by mining existing UCDMC electronic systems. This means that every infection identified still requires chart review for 40% (or 42) of the data points. We are currently exploring the I-Know program, which mines concepts rather than words, to see if that improves the data collection burden.

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: Milestone 9.4: Report at least 6 months of data collection on SSI to SNI for purposes of establishing a baseline and setting benchmarks.
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	67.00
Denominator (if absolute number, enter "1")	*	3,476.00
Achievement		0.02
If "yes/no" as to whether the milestone has been achieved, 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

9.4 Metric: At least 6 months of data collection on surgical site infections reported to SNI for purposes of establishing the baseline and setting benchmarks.

In DY-7 (July 1, 2011 – June 30, 2012), we had a surgical site infection rate of 1.93% (67 surgical site infections out of 3,476 surgeries performed) and would like to use this rate for our surgical site infection baseline. In the first half of DY-7 (July 1, 2011 – December 30, 2011), we had a surgical site infection rate of 2.60% (42 surgical site infections out of 1,618 surgeries performed). In the second half of DY-7 (January 1, 2012 – June 30, 2012), we had a surgical site infection rate of 1.35% (25 surgical site infections out of 1,858 surgeries performed). We are following surgical site infections across 11 procedural areas (eg, colon, rectal, c-section, gastric, hernia, hysterectomy, prostate, neck, knee replacement, hip replacement, and small bowel). The annual DY-7 infection rate for each surgical procedure is as follows: 1) colon surgery: 3.94% (11 surgical site infections out of 279 surgeries performed); 2) rectal surgery: 5.26% (3 surgical site infections out of 57 surgeries performed); 3) c-section: 0.37% (2 surgical site infections out of 537 surgeries performed); 4) gastric surgery: 1.01% (3 surgical site infections out of 297 surgeries); 5) hernia repair: 0.59% (5 surgical site infections out of 843 surgeries); 6) hysterectomy: 1.88% (6 surgical site infections out of 320 surgeries); 7) knee replacement: 1.92% (6 surgical site infections out of 312 surgeries); 8) neck surgery: 6.45% (8 surgical site infections out of 124 surgeries); 9) prostate surgery: 3.45% (3 surgical site infections out of 87 surgeries); 10) small bowel surgery: 7.73% (17 surgical site infections out of 220 surgeries); and 11) hip replacement: 0.75% (3 surgical site infections out of 400 surgeries).

The interventions used to achieve this reduction are reported in Project 9.3 and have allowed us to reduce surgical site infections by 48% between the two six-month reporting periods of DY-7.

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

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:	*	

Category 4: Surgical Site Infection Prevention

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

Achievement Value

Category 4: Surgical Site Infection 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

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: The University of California, Davis Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/26/2012

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 (*).*

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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:	*	$ 1,905,751.00
Incentive Funding Already Received in DY:	*	$ 1,429,313.50

Prevalence of Stage II, III, IV or unstagable pressure ulcers (%)

Numerator	*	13.00
Denominator	*	1,481.00
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):

Metric 10.4: Hospital-acquired pressure ulcer prevalence results reported to the State.

For DY-7 (July 1, 2011 – June 30, 2012), our HAPU prevalence rate was 0.88 (13 HAPUs reported out of 1,481 patients surveyed). In the first half of DY-7 (July 1, 2011 – December 30, 2011), the HAPU prevalence rate was 0.96 (7 HAPUs reported out of 732 patients surveyed). In the second half of DY-7 (January 1, 2012 – June 301, 2012), the HAPU prevalence rate was 0.80 (6 HAPUs reported out of 749 patients surveyed). The interventions used to achieve this reduction are reported in Project 10.3 and have allowed us to report a HAPU prevalence of less than 1.1%, which is the goal for DY-10. Per Safety Net Institute specifications for this measure, we have excluded patients under age 16 as well as stage I HAPUS and DTIs.

DY Target (from the DPH system plan)	*	
% Achievement of Target		N/A
Achievement Value		1.00

Optional Milestone: Milestone 10.3: Share data, promising practices and findings with SNI to foster shared learning and benchmarking across 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

Metric 10.3: Data, promising practices, and findings shared with SNI to foster shared learning and benchmarking across the California public hospitals.

This project is supported by the Skin Wound Assessment-Treatment (SWA-T) team, which is led by wound-certified nurse practitioner Holly Kirkland-Walsh, FNP, GNP. The team consists of an attending physician in plastic surgery, a physical therapist, a dietician, and six registered nurses. The SWA-T team meets weekly to discuss interventions and patients' progress. Every patient who develops a pressure ulcer in the hospital is referred to this team for expert consultation and documentation. This team has been involved in the tracking of pressure ulcers in the inpatient (from admission through discharge) and outpatient settings. The National Database of Nursing Quality Indicators (INDNQI) is the quarterly survey performed by groups of nurses in which data are gathered on pressure ulcer prevalence and documentation is obtained on prevention interventions. This data collection also provides a chance to promote best practices within the hospital system. We are always investigating new products that will aid with the prevention of hospital-acquired pressure ulcers (HAPUs). We performed pressure mapping of every patient surface in the entire hospital. This allows us to gather empirical evidence on the performance of specialty surfaces. We are currently using waffle mattresses and low air loss mattresses throughout

Category 4: Hospital-Acquired Pressure Ulcer Prevention

the hospital and are testing surfaces to be used for long procedures in the operating room. The pressure mapping machine was purchased with a “Children’s Miracle Network Grant.” This equipment allows us to pressure map patients for their specific surface needs and to assure proper positioning to decrease pressure on bony prominences. The work flow is such that we have several ways in which to discover patients at risk and/or in the early stages in the development of pressure ulcers: 1) nurses perform the Braden Risk Assessment Scale on admission and every 12 hours, with audits showing 98% compliance with completion; 2) nurses alert the SWA-T team early in the admission of a patient at risk; 3) the NP in charge of this project has the ability to run daily reports to assess patients at higher risk; 4) specialty surfaces and other supplies do not need to be ordered by physicians to implement a pressure ulcer prevention intervention; and 5) photos are taken and imbedded in the electronic health record (EHR) so that all staff may see the progress of the skin integrity. The SWA-T team continues to educate hospital staff on documentation of pressure ulcers “Present on Admission.” The team has made PowerPoint presentations to nurses in each unit of the hospital and presented a poster to medical staff on the identification and progression of deep tissue injuries. A significant challenge has been documenting HAPU assessment in the EHR. We previously had our Braden Risk Assessment Scale and SKIN bundle together to remind nurses to perform interventions and complete documentation. SKIN is a pneumonic for interventions to prevent pressure ulcers: Surfaces (bed, gurney, etc.), Keep turning and repositioning patient (may need lift team), Incontinence management (foley, butt balm, etc.), Nutrition (check hydration, weight, etc). Recently, an EHR enhancement was initiated that scattered the SKIN bundle. Although our outcomes have remained good, we have had issues with documentation compliance on prevention interventions. The project shared data for promising practices and findings with the Safety Net Institute (SNI) to foster shared learning and benchmarking across California public hospitals. Two posters were shared with SNI in December 2011. One outlined how to change a documentation system for pressure ulcer prevention in 10 days or less. The other poster depicted the SWA-T team’s work on reducing the incidence of pressure ulcers in peri-operative areas.

For DY-7 (July 1, 2011 – June 30, 2012), our HAPU prevalence rate was 0.88 (13 HAPUs reported out of 1,481 patients surveyed). In the first half of DY-7 (July 1, 2011 – December 30, 2011), the HAPU prevalence rate was 0.96 (7 HAPUs reported out of 732 patients surveyed). In the second half of DY-7 (January 1, 2012 – June 301, 2012), the HAPU prevalence rate was 0.80 (6 HAPUs reported out of 749 patients surveyed). Per SNI specifications for this measure, we have excluded patients under age 16 as well as stage I HAPUS and DTIs.

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: ____________________

(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: Hospital-Acquired Pressure Ulcer 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: Hospital-Acquired Pressure Ulcer 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: Hospital-Acquired Pressure Ulcer 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