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

* **DPH SYSTEM:**	Alameda County Medical Center
* **REPORTING YEAR:**	DY 7
* **DATE OF SUBMISSION:**	

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	$ -
Implement and Utilize Disease Management Registry Functionality	$ 1,224,937.50
Expand Specialty Care Capacity	$ 1,837,406.25
Enhance Performance Improvement and Reporting Capacity	$ 3,266,500.00
TOTAL CATEGORY 1 INCENTIVE PAYMENT:	$ 6,328,843.75
Category 2 Projects	
Expand Medical Homes	$ -
Expand Chronic Care Management Models	$ -
Redesign to Improve Patient Experience	$ -
Improve Patient Flow in the Emergency Department/Rapid Medical Evaluation	$ -
Implement/Expand Care Transitions Programs	$ 3,920,000.00
TOTAL CATEGORY 2 INCENTIVE PAYMENT:	$ 3,920,000.00
Category 3 Domains	
Patient/Care Giver Experience *(required)*	$ 3,324,750.00
Care Coordination *(required)*	$ -
Preventive Health *(required)*	$ -
At-Risk Populations *(required)*	$ -
TOTAL CATEGORY 3 INCENTIVE PAYMENT:	$ 3,324,750.00
Category 4 Interventions	
Severe Sepsis Detection and Management *(required)*	$ 937,750.00
Central Line Associated Blood Stream Infection Prevention *(required)*	$ 1,641,062.50
Surgical Site Infection Prevention	$ 468,875.00
Hospital-Acquired Pressure Ulcer Prevention	$ 1,406,625.00
TOTAL CATEGORY 4 INCENTIVE PAYMENT:	$ 4,454,312.50
TOTAL INCENTIVE PAYMENT	$ 18,027,906.25

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION:

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:	Develop plan and initiate construction to expand primary care capacity in ACMC Oakland clinic sites; and increase encounters by 15% by DY10 as compared to ACMC FY 2011. Metric: Final approved plan to expand primary care capacity at ACMC Oakland clinic sites.	No
Achievement Value		-
Process Milestone:	Submit a business plan to add a 24/7 nurse advice telephone line for all primary care clinic patients. Metric: Documentation of approval of above plan.	No
Improvement Milestone:	Expand primary care encounters in Southern Alameda County (Newark Clinic) by 5% compared to baseline (ACMC FY 2010). Metric: Newark Clinic encounter data for baseline and demonstration year.	0.48
Achievement Value		-
DY Total Computable Incentive Amount:		$ 4,899,750.00
Total Sum of Achievement Values:		-
Total Number of Milestones:		3.00
Achievement Value Percentage:		0%
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:	Train 75% of providers and staff at all ACMC primary care clinics in the use and principles of ACMC's disease management registry, including training in the chronic care model and panel management. Metric: Training logs, agendas, presentations and participant learning survey.	0.39
Achievement Value		*0.50*
Process Milestone:	All four primary care clinics at ACMC will have at least one full time panel manager who will populate the registry and establish a process for accurate panel identification and assignment. Metric: "Cleaned" and validated panel reports (reviewed for accuracy of diagnosis and updated patient enrollment status) for all primary care clinics.	No
Achievement Value		-
DY Total Computable Incentive Amount:		$ 4,899,750.00
Total Sum of Achievement Values:		0.50
Total Number of Milestones:		2.00
Achievement Value Percentage:		25%
Eligible Incentive Funding Amount:		$ 1,224,937.50
Incentive Funding Already Received in DY:		$ -
Incentive Payment Amount:		$ 1,224,937.50

Expand Specialty Care Capacity

Process Milestone:	Develop business plan to increase cardiology, dermatology, and orthopedic encounters by 15% each compared to baseline (ACMC FY 2011), by DY10. Metric: Business plan approval documented.	No
Achievement Value		-
Improvement Milestone:	Increase optometry encounters by 20% compared to baseline (ACMC FY 2010). Metric: Encounter data for baseline and demonstration year.	0.97
Achievement Value		*0.75*
DY Total Computable Incentive Amount:		$ 4,899,750.00
Total Sum of Achievement Values:		0.75
Total Number of Milestones:		2.00
Achievement Value Percentage:		38%
Eligible Incentive Funding Amount:		$ 1,837,406.25
Incentive Funding Already Received in DY:		$ -
Incentive Payment Amount:		$ 1,837,406.25

Category 1 Summary Page

Enhance Performance Improvement and Reporting Capacity

Process Milestone:	By mid-year, establish the System Transformation Center: hire staff, establish job duties, set oversight and reporting structures, and develop a four-year work plan. Metric: Documentation of establishment of Center, evidence of hiring, and work plan submission.	No
Achievement Value		-
Process Milestone:	By year's end, System Transformation Center facilitates (via research, grant-writing, and coaching) ACMC's participation in at least three non-mandated statewide, public hospital or national clinical databases or learning collaboratives. Metric: Evidence of participation.	Yes
Achievement Value		*1.00*
Process Milestone:	Complete and sign a services contract to implement three-year Lean-Six-Sigma training initiative at ACMC. Metric: Completed contract	Yes
Achievement Value		*1.00*

DY Total Computable Incentive Amount:	$ 4,899,750.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	3.00
Achievement Value Percentage:	67%
Eligible Incentive Funding Amount:	$ 3,266,500.00
Incentive Funding Already Received in DY:	$ -
Incentive Payment Amount:	$ 3,266,500.00

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION:

Category 2 Summary Page

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Category 2 Projects

Expand Medical Homes

Process Milestone:	Based on DY6's baseline profile of patients seen who lack a medical home, develop a plan to connect patients to a medical home that contains the following elements: - per-provider panel size definitions - a priority classification for patients - a tracking database for these patients - a communication plan between the ED, Specialty Clinics and Primary Care Clinics both within ACMC and at non-ACMC locations. Metric: Plan written and adopted.	No
DY Total Computable Incentive Amount:		$ 3,920,000.00
Total Sum of Achievement Values:		-
Total Number of Milestones:		1.00
Achievement Value Percentage:		0%
Eligible Incentive Funding Amount:		$ -
Incentive Funding Already Received in DY:		$ -
Incentive Payment Amount:		$ -

Expand Chronic Care Management Models

Process Milestone:	Conduct utilization and financial analysis of DY6 disease-specific pilots, after six months of operation. Metric: report documenting costs and health care utilization patterns.	No
Achievement Value		-
Process Milestone:	Develop business plan to expand the care management model beyond chronic hepatitis and chronic pain to include care of complex patients (e.g., homeless, mentally ill, and patients with multiple chronic medical illnesses) requiring care coordination and interdisciplinary care resources. Metric: Documentation of plan, including staffing model, budget, space and scheduling logistics.	No
DY Total Computable Incentive Amount:		$ 3,920,000.00
Total Sum of Achievement Values:		-
Total Number of Milestones:		2.00
Achievement Value Percentage:		0%
Eligible Incentive Funding Amount:		$ -
Incentive Funding Already Received in DY:		$ -
Incentive Payment Amount:		$ -

Category 2 Summary Page

Redesign to Improve Patient Experience

Process Milestone:	Adopt a model for improved nurse-to-patient communication and design curriculum and education plan. Metric: Document the communication model adopted as formal policy and procedure, and document curriculum and plan completed.	No
DY Total Computable Incentive Amount:		$ 3,920,000.00
Total Sum of Achievement Values:		-
Total Number of Milestones:		1.00
Achievement Value Percentage:		0%
Eligible Incentive Funding Amount:		$ -
Incentive Funding Already Received in DY:		$ -
Incentive Payment Amount:		$ -

Improve Patient Flow in the Emergency Department/Rapid Medical Evaluation

Process Milestone:	Identify and implement three improvement interventions and monitor and report their impact on flow. Metric: Reports documenting interventions and results.	No
DY Total Computable Incentive Amount:		$ 3,920,000.00
Total Sum of Achievement Values:		-
Total Number of Milestones:		1.00
Achievement Value Percentage:		0%
Eligible Incentive Funding Amount:		$ -
Incentive Funding Already Received in DY:		$ -
Incentive Payment Amount:		$ -

Implement/Expand Care Transitions Programs

Process Milestone:	Implement a pilot of post-discharge phone based care management protocol in one medical-surgical unit. Patient population will be targeted based on diagnoses and patient characteristics identified by analysis of internal readmission data as having high risk for readmission. Metric: Contact logs, results from pilot, and analysis identifying critical factors for wider implementation.	Yes
Achievement Value		*1.00*
DY Total Computable Incentive Amount:		$ 3,920,000.00
Total Sum of Achievement Values:		1.00
Total Number of Milestones:		1.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 3,920,000.00
Incentive Funding Already Received in DY:		$ -
Incentive Payment Amount:		$ 3,920,000.00

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION:

Category 3 Summary Page

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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 Decision-making” theme to the State (DY8-10)	N/A
Achievement Value	
DY Total Computable Incentive Amount:	$ 3,324,750.00
Total Sum of Achievement Values:	1.00
Total Number of Milestones:	1.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 3,324,750.00
Incentive Funding Already Received in DY:	$ -
Incentive Payment Amount:	$ 3,324,750.00

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION:

Category 4 Summary Page

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

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The red boxes indicate Total Sums.

Category 4 Interventions		
Severe Sepsis Detection and Management *(required)*		
Compliance with Sepsis Resuscitation bundle (%)		0.40
Achievement Value		*0.50*
Sepis Mortality (%)		N/A
Achievement Value		*N/A*
Optional Milestone:	Implement the Sepsis Resuscitation Bundle, as evidenced by: policy & procedures, training records, team meeting minutes, sepsis screen tools used by ED and inpatient nursing	Yes
Achievement Value		*1.00*
Optional Milestone:	Report at least 6 months of data collection on Sepsis Resuscitation Bundle to SNI for purposes of establishing the baseline and setting benchmarks.	N/A
Achievement Value		-
DY Total Computable Incentive Amount:		$ 1,875,500.00
Total Sum of Achievement Values:		1.50
Total Number of Milestones:		3.00
Achievement Value Percentage:		50%
Eligible Incentive Funding Amount:		$ 937,750.00
Incentive Funding Already Received in DY:		$ -
Incentive Payment Amount:		$ 937,750.00

Category 4 Summary Page

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

Compliance with Central Line Insertion Practices (CLIP) (%)		0.99
Achievement Value		0.50
Central Line Bloodstream Infection (Rate per 1,000 patient days)		N/A
Achievement Value		
Optional Milestone:	Implement the Central Line Insertion Practices (CLIP), as evidenced by policy & procedures, training records, central line insertion carts, logs of cart checks, team meeting minutes, checklist /CLIP form, ICU daily assessment sheets	Yes
Achievement Value		*1.00*
Optional Milestone:	Report at least 6 months of data collection on CLIP to SNI for purposes of establishing the baseline and setting benchmarks	-
Achievement Value		*1.00*
Optional Milestone:	Report at least 6 months of data collection on CLABSI to SNI for purposes of establishing the baseline and setting benchmarks.	Yes
Achievement Value		*1.00*
DY Total Computable Incentive Amount:		$ 1,875,500.00
Total Sum of Achievement Values:		3.50
Total Number of Milestones:		4.00
Achievement Value Percentage:		88%
Eligible Incentive Funding Amount:		$ 1,641,062.50
Incentive Funding Already Received in DY:		$ -
Incentive Payment Amount:		$ 1,641,062.50

Surgical Site Infection Prevention

Rate of surgical site infection for Class 1 and 2 wounds (%)		N/A
Achievement Value		-
Optional Milestone:	Report at least 6 months of data collection on SSI to the California Safety Net Institute and identify the three top procedures causing SSI at ACMC for purposes of establishing the baseline and setting benchmarks.	0.67
Achievement Value		*0.50*
Optional Milestone:	-	N/A
Achievement Value		
DY Total Computable Incentive Amount:		$ 1,875,500.00
Total Sum of Achievement Values:		0.50
Total Number of Milestones:		2.00
Achievement Value Percentage:		25%
Eligible Incentive Funding Amount:		$ 468,875.00
Incentive Funding Already Received in DY:		$ -
Incentive Payment Amount:		$ 468,875.00

Category 4 Summary Page

Hospital-Acquired Pressure Ulcer Prevention

Prevalence of Stage II, III, IV or unstageable pressure ulcers (%)		0.03
Achievement Value		*0.50*
Optional Milestone:	Share data, promising practices, and findings with SNI to foster shared learning and benchmarking across the California public hospitals.	Yes
Achievement Value		*1.00*
Achievement Value		
DY Total Computable Incentive Amount:		$ 1,875,500.00
Total Sum of Achievement Values:		1.50
Total Number of Milestones:		2.00
Achievement Value Percentage:		75%
Eligible Incentive Funding Amount:		$ 1,406,625.00
Incentive Funding Already Received in DY:		$ -
Incentive Payment Amount:		$ 1,406,625.00

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION:

REPORTING ON THIS PROJECT: * No

Category 1: Expand Primary Care Capacity

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

DY Total Computable Incentive Amount: * $ 4,899,750.00

Incentive Funding Already Received in DY: *

Process Milestone: Develop plan and initiate construction to expand primary care capacity in ACMC Oakland clinic sites; and increase encounters by 15% by DY10 as compared to ACMC FY 2011. Metric: Final approved plan to expand primary care capacity at ACMC Oakland clinic sites.

(insert milestone)

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

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

Achievement: No

If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and (if "yes") provide an in-depth description of how the milestone was achieved: * No

ACMC has engaged the services of an experienced financial planner and analyst to assist with budgeting, forecasting, and financial modeling for this and the other business plans that are part of our DY7 milestones. Planning for primary care expansion is well underway. In addition, remodeling of existing space on Highland Campus and at Eastmont Wellness Center, both in Oakland, is underway.

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

Achievement Value -

Process Milestone: Submit a business plan to add a 24/7 nurse advice telephone line for all primary care clinic patients. Metric: Documentation of approval of above plan.

(insert milestone)

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

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

Achievement: No

If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and (if "yes") provide an in-depth description of how the milestone was achieved: * No

The business plan for the 24/7 nurse advice line is almost complete. The new financial planner mentioned above is working with Ambulatory Healthcare Services division management to complete the financial analysis, and the plan will be submitted for approval to the ACMC DSRIP Oversight Committee before the end of DY7.

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

Achievement Value -

Category 1: Expand Primary Care Capacity

Improvement Milestone: Expand primary care encounters in Southern Alameda County (Newark Clinic) by 5% compared to baseline (ACMC FY 2010). Metric: Newark Clinic encounter data for baseline and demonstration year.

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	11,756.00
Denominator (if absolute number, enter "1")	*	24,657.00
Achievement		0.48
If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and (if "yes") provide an in-depth description of how the milestone was achieved:	*	No

The construction at Newark Clinic is complete; however the volume has not yet increased as anticipated.

Community marketing and word-of-mouth about the increased availability of services such as women's health has not fully reached the potential client base. We are working with our new Marketing and Communications Director on marketing strategies, and in addition the new clinic manager is networking with community leaders to raise the profile of the expanded services.

We plan to add Saturday clinic hours so that we can draw more patients who can access services only during non-work hours. We are actively recruiting for more providers to cover additional clinic sessions.

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

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION:

REPORTING ON THIS PROJECT: * Yes

Category 1: Implement and Utilize Disease Management Registry Functionality

Below is the data reported for the DPH system.
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Implement and Utilize Disease Management Registry Functionality

DY Total Computable Incentive Amount: * $ 4,899,750.00

Incentive Funding Already Received in DY: * $ -

Process Milestone: Train 75% of providers and staff at all ACMC primary care clinics in the use and principles of ACMC's disease management registry, including training in the chronic care model and panel management. Metric: Training logs, agendas, presentations and participant learning survey.

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * 80.00

Denominator (if absolute number, enter "1") * 203.00

Achievement 0.39

If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and (if "yes") provide an in-depth description of how the milestone was achieved: *

Numerator = # trained; denominator = # of relevant providers and staff who are deemed to need training as part of the panel management program.

ACMC is actively developing and spreading the panel management program in our four adult primary care clinics. Numerous trainings have been offered for staff at all service locations; audience includes adult medicine providers (including residents), and relevant clinical staff, including MAs, nurses, social workers, health educators, eligibility clerks, and others. Topics include chronic care model, principles of panel management, use of ACMC disease registry (i2i tracks), and the specifics of the ACMC panel management program.

The Internal Medicine faculty has developed an extensive panel management practicum using the Chronic Care Model components for internal medicine and primary care residents. The practicum comprises: 1) A didactic session during which we present a biopsychosocial approach to four major areas of chronic care; diabetes, cardiovascular disease, chronic pain and health care maintenance; 2) Use of an electronic population management tool to identify discrepancies between standard and actual care of resident's continuity patients; 3) Resident development and implementation of population management activities to close identified gaps in care and 4) instruction in motivational interviewing-based communication techniques. Residents collaborate with a care team including a panel manager, a social worker, a clinical pharmacist, and medical assistants. Residents complete the practicum during eleven half-day sessions per year, during which four residents are supervised by one faculty member.

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

Achievement Value 0.50

Category 1: Implement and Utilize Disease Management Registry Functionality

Process Milestone: All four primary care clinics at ACMC will have at least one full time panel manager who will populate the registry and establish a process for accurate panel identification and assignment. Metric: “Cleaned” and validated panel reports (reviewed for accuracy of diagnosis and updated patient enrollment status) for all primary care clinics.

(insert milestone)

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

We are not reporting on the metric at this time. However, we have made a great deal of progress toward implementing panel management.

As of 12/31/2012, three of the four Panel Management Coordinator positions had been filled. A panel management protocol which includes diabetes, hypertension, Pap tests, mammograms, CRC screening, pneumococcal and influenza vaccine is complete. Telephone scripts, health education materials and process flow diagrams have been developed; two providers at each outpatient clinic had been identified (they are currently piloting the protocol); and a chart audit to collect baseline data was underway. Program goals and program brochure were in draft format, and a process for “scrubbing” provider panels had been developed. Additionally, the process of empanelling patients is underway, including the definition of “active” patient and “primary care provider”, as well as the protocol for assigning patients to a “primary care provider”.

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

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County Medical Center
REPORTING YEAR: DY 7
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REPORTING ON THIS PROJECT: * Yes

Category 1: Expand Specialty Care Capacity

Below is the data reported for the DPH system.
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Expand Specialty Care Capacity

DY Total Computable Incentive Amount: * $ 4,899,750.00

Incentive Funding Already Received in DY: *

Process Milestone: Develop business plan to increase cardiology, dermatology, and orthopedic encounters by 15% each compared to baseline (ACMC FY 2011), by DY10. Metric: Business plan approval documented.
(insert milestone)

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

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

Achievement: No

If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and (if "yes") provide an in-depth description of how the milestone was achieved: * No

ACMC has engaged the services of an experienced financial planner and analyst to assist with budgeting, forecasting, and financial modeling for this and the other business plans that are part of our DY7 milestones. With his assistance, the planning for specialty care expansion is well underway. In addition, remodeling of existing space on Highland Campus and at Eastmont Wellness Center, both in Oakland, is underway.

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

Achievement Value -

Category 1: Expand Specialty Care Capacity

Improvement Milestone: Increase optometry encounters by 20% compared to baseline (ACMC FY 2010). Metric: Encounter data for baseline and demonstration year.

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	2,824
Denominator (if absolute number, enter "1")	*	2,899
Achievement		0.97
If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and (if "yes") provide an in-depth description of how the milestone was achieved:	*	

Baseline = 2,899 (fy2010); denominator = 2,899; numerator = # visits as of 12/31/11

In 2011 ACMC expanded access to optometry services by moving from 3 to 6 days of service at Eastmont. This increased service availability by 100%, including glaucoma and diabetic screening. The wait time for appointments dropped from over 6 months to approximately 3 months. This was achieved by increasing our partnership with UC Berkeley and adding another optometry room at Eastmont. At Newark Health Center, retinal screening began in October 2011. A new Saturday clinic was scheduled to open at Highland in January 2012.

As an illustration of the significance of this change, we include this case report from one of the providers: *Ms. L is an Asian female in her early 50s who had not had access to vision care for a long time. After examining her, the doctor found she had un-diagnosed diabetes that was threatening her eye-sight. This patient had no idea she had diabetes. A prompt referral to Highland ophthalmology and her primary care physician was made and within days she was seen for laser treatment by an ophthalmologist and management of diabetes by her PCP.* "I believe that because we were able to see this patient soon enough, due to our expanded service and shorter wait time, she has a chance of preserving decent vision and avoiding continued damage to her vital organs." – Dr. L

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	*	1.20
Achievement Value		0.75

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION:

REPORTING ON THIS PROJECT: * Yes

Category 1: Enhance Performance Improvement and Reporting Capacity

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

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Enhance Performance Improvement and Reporting Capacity

DY Total Computable Incentive Amount: * $ 4,899,750.00

Incentive Funding Already Received in DY: *

Process Milestone: By mid-year, establish the System Transformation Center: hire staff, establish job duties, set oversight and reporting structures, and develop a four-year work plan. Metric: Documentation of establishment of Center, evidence of hiring, and work plan submission.

(insert milestone)

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

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

Achievement: No

If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and (if "yes") provide an in-depth description of how the milestone was achieved: * No

The establishment of the System Transformation Center (STC) was underway, but not complete as of 12/31/2011. Key staff roles were identified and were being recruited for, including the STC Executive Director, DSRIP Administrator, a Business Analyst, an Organizational Development expert, and others. The oversight and reporting structures were set up and implemented. An Oversight Committee comprising executive and medical staff leadership was established in June 2011, and meets monthly to review progress on milestones and approve funding for projects. A clear vision established by the STC Plan created in DY6 has guided the spending decisions made, ensuring the DSRIP dollars are used for system change and not folded into operations. An accountability structure for leadership of all of the projects is in place and project teams are engaged and active.

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

Achievement Value -

Category 1: Enhance Performance Improvement and Reporting Capacity

Process Milestone: By year's end, System Transformation Center facilitates (via research, grant-writing, and coaching) ACMC's participation in at least three non-mandated statewide, public hospital or national clinical databases or learning collaboratives. Metric: Evidence of participation.

(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 (if "yes") provide an in-depth description of how the milestone was achieved: * Yes

ACMC staff have participated in several learning collaboratives this year, including:
1. **Avoiding Readmissions through Collaboration (ARC)** is a partnership between the Center for Quality System Improvement (CQSI) and the California Quality Collaborative (CQC), funded by the Gordon and Betty Moore Foundation, with supplemental support from the California HealthCare Foundation. The aim is to reduce 30 and 90 day all cause readmission rates by 30% by 2013. As part of ARC, ACMC has established a multi-disciplinary team, conducted process analysis, and created and formally adopted a plan to achieve the aim. The plan integrates many of the DSRIP projects. We have participated in quarterly learning sessions, and monthly calls to share information and best practices.

2. **PExT (Patient Experience Transformation)** is a 9 month collaborative program aimed at helping public hospital systems achieve measurable advances in the patient and caregiver experience. It is sponsored by the Safety Net Institute (SNI) in partnership with ExperiaHealth, and began in October 2011. ACMC has been participating since October 2011. The collaborative provides coaching, roadmaps, tools, resources and structure to help ACMC refine our approach to providing excellent customer service. ACMC is participating in live trainings, webinars and networking opportunities with other public healthcare organizations also involved in the program. In particular, our team is using the free expertise offered through this program to develop a customer service training curriculum. The team is planning an 8 hour design session at which we will work with a multi-disciplinary team of line staff to map the gaps in inpatient nursing communication skills and then develop a training program to address these gaps and identify some "quick wins".

3. The **ELNEC (End-of-Life Nursing Education Consortium) Public Hospital Project** is a two-year collaborative supporting palliative care nursing which began in November 2011. It is funded by the California HealthCare Foundation in collaboration with the Safety Net Institute and UCSF's Palliative Care Leadership Center (PCLC). ACMC participated in a Train-the-Trainer course that covered core nursing concepts in palliative care, including pain and symptom management, communication, culture, ethics, loss/grief/bereavement, care in the final days and hours, leadership and integration of evidence into policy and practice. This course provided model teaching strategies and skills to prepare the attendees to teach important palliative care concepts to nurses in their home facilities. A site-specific work plan and outcome measures metric was developed as part of the course. The program will provide ongoing trainings via website and onsite educational sessions that ACMC staff will participate in.

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

Achievement Value 1.00

Category 1: Enhance Performance Improvement and Reporting Capacity

Process Milestone: Complete and sign a services contract to implement three-year Lean-Six-Sigma training initiative at ACMC. Metric: Completed contract

(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 (if "yes") provide an in-depth description of how the milestone was achieved:	* Yes

ACMC is actively engaged in an intensive Lean training and process improvement program. A three-year contract with leading Lean consulting firm, Rona Consulting Group, was signed on August 1, 2011. On August 18 and 19, 2011, a leadership training institute was held that was attended by most of the executive and medical staff leadership. During the Fall, multiple value stream mapping and kaizen events were planned to take place during the first quarter of 2012.

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

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION:

REPORTING ON THIS PROJECT: * No

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 (*).*
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Expand Medical Homes

DY Total Computable Incentive Amount: * $ 3,920,000.00

Incentive Funding Already Received in DY: *

Process Milestone:

Based on DY6's baseline profile of patients seen who lack a medical home, develop a plan to connect patients to a medical home that contains the following elements:
- per-provider panel size definitions
- a priority classification for patients
- a tracking database for these patients
- a communication plan between the ED, Specialty Clinics and Primary Care Clinics both within ACMC and at non-ACMC locations.
Metric: Plan written and adopted.

(insert milestone)

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

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

Achievement: No

If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and (if "yes") provide an in-depth description of how the milestone was achieved: * No

The analysis and discussion that is necessary to develop different elements of the plan is underway and we anticipate the formal plan will be written and approved by the end of DY7.

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

Achievement Value -

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION:

REPORTING ON THIS PROJECT: * No

Category 2: Expand Chronic Care Management Models

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

DY Total Computable Incentive Amount: * $ 3,920,000.00

Incentive Funding Already Received in DY: *

Process Milestone: Conduct utilization and financial analysis of DY6 disease-specific pilots, after six months of operation. Metric: report documenting costs and health care utilization patterns.
(insert milestone)

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

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

Achievement: No

If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and (if "yes") provide an in-depth description of how the milestone was achieved: * No

Analysis of utilization and financial impacts of the pain management and Hepatitis C clinic is underway.

One of ACMC's milestones (below) is to establish a Complex Care Clinic that provides coordinated care to patients with highly complex chronic medical and psycho-social conditions (e.g., homelessness, mental illness, multiple chronic medical conditions, uncontrolled pain) that require intensive care management to optimize health and healthcare utilization. We expect that this enhanced care management for the most complex patients will help all of our other services operate more smoothly, reducing inappropriate utilization and costs, while improving care. As a first step toward the development of the Complex Care Clinic at ACMC, the Hepatitis C and Pain Clinics were launched in FY 2011.

The Hepatitis C Clinic opened in February 2011, led by a national expert on the management of Hep C in indigent populations. The Pain Clinic opened in June 2011. Both clinics have multidisciplinary teams that include e.g., physician's assistant, social worker, psychologist, and physical therapist.

As an illustration of the importance of these services to the patients, we include this case report from one of the providers: *Ms. D is a 62 year old woman who recently came to ACMC's new Pain Management Clinic for help. Ten years ago a car-vs.-motor scooter accident left her with chronic ankle, neck, back and shoulder pain which had made it impossible for her to work; she found herself homeless, without psychosocial support and living in poverty. Previous medical treatment she received did not relieve her condition. She was despondent, depressed, and hopeless due to the chronic pain. The novel, multidisciplinary approach of the new clinic has made a real difference. The clinic team helped her switch from hydrocodone to Subutex, enrolled her in our psycho-educational group, and began individual counseling and physical therapy. Ms. D. has developed new skills to help with pain, insomnia, isolation and depression. She is stable on a small dose of Subutex (1mg twice a day), is working, and manages her stress through meditation, not medication. She is a success in every respect of the word.*

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

Achievement Value -

Category 2: Expand Chronic Care Management Models

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

(insert milestone)

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

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

Achievement: No

If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and (if "yes") provide an in-depth description of how the milestone was achieved: * No

ACMC is developing a complex care coordination model that we have named the HOPE Center. Phase I of development, which included research and initial planning and design for the clinic, concluded in January. Phase II is underway, and will include financial modeling, plan finalization and early implementation. A Program Administrator and Medical Director/clinician are being recruited. We anticipate opening of the HOPE Center in the first quarter of FY 2012 with the goal of serving a panel of at least 200 patients by the end of FY2013.

The research phase included comprehensive literature reviews, informational interviews with leaders in the field of chronic and complex care, key stakeholder interviews within ACMC, monthly presentation of research findings at HOPE Center Steering committee meetings, steering committee consensus-building for key features to incorporate into the HOPE model. The HOPE steering committee comprises representatives from ambulatory services, quality, inpatient service, psychiatry, and hospital administration. Three sub-committees have met to design specific components of the clinic (patient selection, staffing model, space).

The vision for the HOPE Center is that through increased emphasis on care coordination and service integration for our system's sickest patients ACMC can achieve:
• Reduced system costs by increased efficiency of care for complex patients
• Improved health outcomes for our most vulnerable patients
• Improved clinic flow and decreased congestion in outpatient clinics

Based on the results of Phase I, the model of the HOPE clinic will include:
• An integrated, patient-centered program of intensive transitional primary care
• A special emphasis on care management, behavioral health integration, and service coordination
• Service to a subset of patients with high medical acuity—likely uncontrolled or multiple chronic conditions—and additional psychosocial or behavioral challenges that make care coordination in a traditional primary care setting challenging
• A care program that builds in the goal of patients returning to usual primary care with better self-management skills and improved integration of care that helps them to succeed at a lower intensity of care
• A physical space that emphasizes patient access and alternate care modalities to the traditional physician-patient encounter, such as telephone and home visits

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

Achievement Value -

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION:

REPORTING ON THIS PROJECT: * No

Category 2: Redesign to Improve Patient Experience

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

DY Total Computable Incentive Amount: * $ 3,920,000.00

Incentive Funding Already Received in DY: * $ -

Process Milestone: Adopt a model for improved nurse-to-patient communication and design curriculum and education plan. Metric: Document the communication model adopted as formal policy and procedure, and document curriculum and plan completed.

(insert milestone)

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

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

Achievement: No

If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and (if "yes") provide an in-depth description of how the milestone was achieved: * No

ACMC has adopted AIDET as its model for improved communication with patients. To ensure ACMC achieves the goal of improving nurse communication scores on HCAHPS by 12% by 2015, we are enhancing and expanding the already-established AIDET customer service training plan and curriculum to make it specific to nurses at ACMC's acute care campus, Highland Hospital.

ACMC was accepted into and is actively participating in the 9 month PExT (Patient Experience Transformation) collaborative program, sponsored by the Safety Net Institute (SNI). (See milestone under Performance Improvement for more detail). As part of the program, our team is developing a customer service training curriculum that is tailored to our own staff. We have completed 17 patient/family and 10 employee interviews, and observations of each inpatient unit, to guide us in developing questions for facilitating employee and patient/family focus groups.

The formal policy and procedure have been drafted and are under review.

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

Achievement Value -

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION:

REPORTING ON THIS PROJECT: * No

Category 2: Improve Patient Flow in the Emergency Department/Rapid Medical Evaluation

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

DY Total Computable Incentive Amount: * $ 3,920,000.00

Incentive Funding Already Received in DY: *

Process Milestone: Identify and implement three improvement interventions and monitor and report their impact on flow. Metric: Reports documenting interventions and results.
(insert milestone)

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

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

Achievement: No

If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and (if "yes") provide an in-depth description of how the milestone was achieved: * No

ACMC's ED Flow project has two goals, one oriented toward reducing length of stay for lower acuity patients, the other toward high acuity patients who are admitted to the hospital. Three improvement projects are underway, two of which are aimed at decreasing length of stay for lower acuity Patients (level 4 & 5), and one for patients being admitted to the hospital.

The first is a pilot test using an intake nurse to rapidly sort patients for level of care. The aim is to shrink arrival to provider time for low acuity patients to the standard of 70 minutes. In CY 2010 the baseline for this measure was 86 minutes. The time for arrival to provider time during Q3&4 2011 was reduced to 65 minutes.

The problem to be solved was that a large volume of low-acuity patients come to the Highland ED for concerns that would be more appropriately addressed in an urgent care setting. All patients were being seen on a first come, first serve basis. The result was overcrowding of the ED, and inappropriately-allocated space and resources to care for truly urgent patients. In October of 2010, the ED created a more appropriate treatment space for lower acuity patients within the ED (called Fastrack), making ED beds more available for sicker patients. Since then, the program has been engaged in cycles of improvements.

The improvement that is being tested currently is the use of an intake RN, replacing a registration clerk as the patient's first point of contact on entering the ED. This RN does a brief assessment to identify acuity (a "rapid sort") and directs the patient to the appropriate area of care, resulting in the patient moving quickly to the Fastrack area. The intake nurse role was piloted in the fall of 2011.

The second improvement project addressing low-acuity patient length of stay is being developed: the "Pull to Full" Initiative. The aim is to make more efficient and timely use of available ED beds. When beds are free, patients identified as needing a bed will be placed right away, and the intake process will be completed with the patient in the bed.

The third improvement project being developed is aimed at decreasing time from the decision to admit to admission to floor: Stable Admit Order Pilot. Emergency Medicine and Internal Medicine are working together on this project to reduce the time taken to assess the patient and write admission orders. When a stable patient is identified, the admission team will write the basic orders needed to facilitate initiation of care and rapid transfer to the floor. Within 6 hours of arrival to the floor, the admitting physician will perform a more complete assessment and write additional orders.

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

Achievement Value -

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION:

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 (*).*

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Implement/Expand Care Transitions Programs

DY Total Computable Incentive Amount: * $ 3,920,000.00

Incentive Funding Already Received in DY: *

Process Milestone: Implement a pilot of post-discharge phone based care management protocol in one medical-surgical unit. Patient population will be targeted based on diagnoses and patient characteristics identified by analysis of internal readmission data as having high risk for readmission. Metric: Contact logs, results from pilot, and analysis identifying critical factors for wider implementation.
(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 (if "yes") provide an in-depth description of how the milestone was achieved: * Yes

The Patient Call Manager (PCM) is a program to call discharged patients within 24-72 hours. The goals of the post-discharge calls are to improve clinical outcomes and patient perception of care and to contribute to the reduction of preventable readmissions. ACMC conducted a pilot test of the PCM calls on one hospital unit. The results from the pilot were positive—we found that patients appreciated receiving the call, and were able to get questions answered regarding medications, dressing changes, and confirming dates for their ambulatory care appointments. Based on this experience, we decided to implement the program for all patients discharged from Highland, not just a subset of high risk patients as had been originally planned.
The Reducing Readmissions Team has been conducting in-depth analysis of internal readmissions data to identify risk factors for readmissions in our patient population, in order to achieve the DY8 milestone of assigning medical homes to high risk patients.

Data from the PCM report for Jul -Dec 2011: 2,478 patients were reached out of a potential pool of 2,907. The non-completed calls were due to wrong numbers (10.5%), do not call preference (3.9%), and dropped after multiple attempts (.4%) .

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

Achievement Value 1.00

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION:

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.*
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Patient/Care Giver Experience (required)

DY Total Computable Incentive Amount: * $ 3,324,750.00

Incentive Funding Already Received in DY: *

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. (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

In July 2011, ACMC established a contract to implement CG-CAHPS. We completed the necessary planning, redesign, translation, and training, and began utilizing CG-CAHPS for our ambulatory care patient experience surveys in September. ACMC staff participated in the development of the standardized approach to implementing CG-CAHPS across all CAPH members.

As part of the development of CG-CAHPS, ACMC:
- Participated in SNI lead sub group to establish proposal for uniform survey sampling, collection, and reporting
- Attended “CG-CAHPS Implementation Network Planning Meeting” where previously prepared Survey proposal was approved
- Worked with SNI planning sub-group to explore viable options for sampling at clinic and provider level. This group created two sampling options for collecting data at the clinic and provider level that could be rolled up into a system-level score required for DSRIP reporting
- Presented at ACMC Ambulatory Operations Council on Questionnaire and Measurement Strategy
- Provided education at staff meeting (Eastmont) on CG-CAHPS Questionnaire, and how score is calculated
- Worked with Press Ganey to transition from vendor-based questionnaire to CG-CAHPS questionnaire, including developing a new phone script
- Switched to CG-CAHPS questionnaire

Achievement: yes

Achievement Value: 1.00

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION:

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 (*).*
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Care Coordination (required)

DY Total Computable Incentive Amount: * $ 3,324,750.00

Incentive Funding Already Received in DY: *

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

Data Collection Source *

Numerator *

Denominator *

Rate

Provide an in-depth description of milestone progress. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

The reports for the required data have been designed and requested from Siemens, ACMC's information systems vendor. Once reports are received, they will be reviewed and refined. We anticipate being able to report the data in the year-end report.

Achievement: N/A

Achievement Value: -

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

Data Collection Source *

Numerator *

Denominator *

Rate

Provide an in-depth description of milestone progress. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

The reports for the required data have been designed and requested from Siemens, ACMC's information systems vendor. Once reports are received, they will be reviewed and refined. We anticipate being able to report the data in the year-end report.

Achievement: N/A

Achievement Value: -

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION:

Category 3: Preventive Health *(required)*

Below is the data reported for the DPH system.

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Preventive Health (required)

DY Total Computable Incentive Amount:	* $ 3,324,750.00
Incentive Funding Already Received in DY:	*

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

Data Collection Source	*
Numerator	*
Denominator	*
Rate	

Provide an in-depth description of milestone progress. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

The reports for the required data have been designed and requested from Siemens, ACMC's information systems vendor. Once reports are received, they will be reviewed and refined. We anticipate being able to report the data in the year-end report.

Achievement	N/A
Achievement Value	-

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

Data Collection Source	*
Numerator	*
Denominator	*
Rate	

Provide an in-depth description of milestone progress. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

The reports for the required data have been designed and requested from Siemens, ACMC's information systems vendor. Once reports are received, they will be reviewed and refined. We anticipate being able to report the data in the year-end report.

Achievement	N/A
Achievement Value	-

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION:

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: *	$ 3,324,750.00
Incentive Funding Already Received in DY: *	

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

Data Collection Source *	
Numerator *	
Denominator *	
Rate	

Provide an in-depth description of milestone progress. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

The reports for the required data have been designed and requested from Siemens, ACMC's information systems vendor. Once reports are received, they will be reviewed and refined. We anticipate being able to report the data in the year-end report.

Achievement	N/A
Achievement Value	-

Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State ***(DY7-10)***

Data Collection Source *	
Numerator *	
Denominator *	
Rate	

Provide an in-depth description of milestone progress. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

The reports for the required data have been designed and requested from Siemens, ACMC's information systems vendor. Once reports are received, they will be reviewed and refined. We anticipate being able to report the data in the year-end report.

Achievement	N/A
Achievement Value	-

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County 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 (*).*

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Severe Sepsis Detection and Management

DY Total Computable Incentive Amount:	* $ 1,875,500.00
Incentive Funding Already Received in DY:	*

Compliance with Sepsis Resuscitation bundle (%)

Numerator	* 46
Denominator	* 115
% Compliance	0.40

Provide an in-depth description of milestone progress. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

The Jan-Jun 2010 rate of compliance to the full sepsis resuscitation bundle, as reported to the Integrated Nurse Leadership Program (INLP), was 26%. The current rate of 40% for Jul-Dec 2011 indicates the Sepsis Harm Reduction Team's work is having an effect. The improvement activities are described below.

DY Target (from the DPH system plan, if appropriate)	*
% Achievement of Target	N/A
Achievement Value	0.50

Sepis Mortality (%)

Numerator	*
Denominator	*
% Mortality	N/A

Provide an in-depth description of milestone progress. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

Not required at this time.

Achievement Value	N/A

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

Optional Milestone: Implement the Sepsis Resuscitation Bundle, as evidenced by: policy & procedures, training records, team meeting minutes, sepsis screen tools used by ED and inpatient nursing

(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 (if "yes") provide an in-depth description of how the milestone was achieved:	* Yes

The interdisciplinary Sepsis harm reduction team has met regularly throughout 2011. Strategies have included:
- Standardizing clinical pathways for diagnosing and treating sepsis
- Raising awareness to improve early diagnosis
- Empowering nurses to act on suspicion of sepsis
- Moving critical tests from lab to point of care
- Speeding up access to appropriate antibiotics

In pursuit of these strategies, the team has added sepsis bundle elements to Smart Orders, developed a nurse early diagnosis screening protocol used at admission and transfer, developed a lab-ordering pathway for nurses to begin diagnosis independent of MDs, put point of care lactate testing on floors, added broad spectrum antibiotics to stock in Emergency Department and Intensive Care Unit, and created an innovative and fun Sepsis Diagnosis video on YouTube. Smart Orders data shows increased use of bundle elements.

As next steps the team plans to:
- Contiue and enhance monitoring of adherence to bundle to be certain of change
- Audit rates of use of screening protocol and POC testing
- Broaden efforts to include more departments

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

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

(insert milestone)

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

ACMC has reported on Sepsis Resuscitation bundle compliance since Dec 2009 to the Integrated Nurse Leadership Program (INLP). This data has not yet been sent to SNI.

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: Alameda County Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION:

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 (*).*
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Central Line Associated Blood Stream Infection

DY Total Computable Incentive Amount:	* $ 1,875,500.00
Incentive Funding Already Received in DY:	* $ -

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

Numerator	* 100.00
Denominator	* 101.00
% Compliance	0.99

Provide an in-depth description of milestone progress. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

Data as reported to NHSN website:
Reporting period: Jul. 1 2011 through Dec. 31, 2011.
The rate was 99% for completeness of CLIP forms: 100/101 forms completed.

DY Target (from the DPH system plan)	*
% Achievement of Target	N/A
Achievement Value	0.50

Central Line Bloodstream Infection (Rate per 1,000 patient days)

Numerator	*
Denominator	*
Infection Rate	N/A

Provide an in-depth description of milestone progress. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

Not required at this time.

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

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

Optional Milestone: Implement the Central Line Insertion Practices (CLIP), as evidenced by policy & procedures, training records, central line insertion carts, logs of cart checks, team meeting minutes, checklist /CLIP form, ICU daily assessment sheets

(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 (if "yes") provide an in-depth description of how the milestone was achieved:	* Yes

The interdisciplinary Device-Associated Infections harm reduction team has met regularly throughout 2011. Strategies have included:

• Standardizing documentation to include reminders of critical prevention elements of care
• Creating a multidisciplinary group to move newly proven equipment/techniques quickly from journal to bedside
• Implementing real time multidisciplinary team review of every event
• Hardwiring improvements

In pursuit of these strategies, the team has standardized protocols for inserting and maintaining central lines and associated dressings (CLIP forms; dressing change bundle; documentation of the need for central lines daily; ultrasound required for all central lines and new ultrasound purchased; simulation man training for performance of procedures); switched to newer equipment (biopatch dressings, new central line access hubs); integrated rapid response team into routine “handoffs” of high risk patients; developed ICU daily progress and goal sheets (the daily goals sheet has reminders for documenting number of days the line is in place and whether a review of daily necessity was performed); CLIP summary cards are attached to ID badges for relevant staff; instituted use of the central line insertion form to remind and document good technique (the CLIP form is now attached to all central lines); and periodic patient safety rounding real time reviews. There is a Central Line Cart on each floor, and inventory and re-stocking are done two times per week. We have also implemented an electronic documentation system for central line information.

As next steps the team plans to:
• Routinely monitor CLIP elements and dressing changes with feedback of performance by MD/RN, by service and by ward
• Reduce the number of central lines placed
• Include adherence to protocols in evaluations, orientations and embed in clinical culture
• Assess feasibility of hiring a vascular access nurse

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

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

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

(insert milestone)

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

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

Achievement

If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and (if "yes") provide an in-depth description of how the milestone was achieved: * Yes

ACMC has been submitting the complete CLIP data set to NHSN since 2008 and the data are available on the website. ACMC conferred NHSN data viewing rights to SNI on Dec 19, 2012.

Data as reported to NHSN website:
Baseline period: Jan 2010-Jun 2010. The rate was 100% for completeness of CLIP forms: 133/133 forms completed.

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

Achievement Value 1.00

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

(insert milestone)

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

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

Achievement Yes

If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and (if "yes") provide an in-depth description of how the milestone was achieved: * Yes

By 12/31/2011, ACMC submitted six months of CLABSI data to SNI.
Baseline period: July 2010-Dec 2010. The infection rate for all critical care units and inpatient units was 9/5023=1.79.

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

Achievement Value 1.00

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION:

REPORTING ON THIS PROJECT: * Yes

Category 4: Surgical Site Infection Prevention

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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Surgical Site Infection Prevention

DY Total Computable Incentive Amount: * $ 1,875,500.00

Incentive Funding Already Received in DY: *

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

Numerator *

Denominator *

% Infection Rate N/A

Provide an in-depth description of milestone progress. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):

Due to the increased demands for surgical site infections reporting, and limited staffing, data collection for DY 7 was not yet complete as of the date of this report. We anticipate reporting the full 12 months of data in the year-end report.

DY Target (from the DPH system plan) *

% Achievement of Target N/A

Achievement Value -

Category 4: Surgical Site Infection Prevention

Optional Milestone: Report at least 6 months of data collection on SSI to the California Safety Net Institute and identify the three top procedures causing SSI at ACMC for purposes of establishing the baseline and setting benchmarks.

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	2.00
Denominator (if absolute number, enter "1")	*	3.00
Achievement		0.67
If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and (if "yes") provide an in-depth description of how the milestone was achieved:	*	

Numerator = 2 procedure reports submitted; denominator = 3 procedures to be reported.

By 12/31/2011, ACMC reported data to SNI on surgical site infection rates for Jan 2010-Jun 2010 for two procedures: Knees/Hips/Arthroplasties and Colon resections. The combined infection rate for these procedures was 14%. We are still analyzing the third priority procedure for improvement

ACMC has submitted SSI data to NHSN and the data are available on the website. ACMC has conferred NHSN data viewing rights to SNI.

The interdisciplinary Surgical Site Infections harm reduction team met regularly throughout 2011. Strategies have included:

- Identifying highest risk/high volume procedures for SSI and tracking them monthly to identify cases of infection
- Monitoring and reinforcing adherence to basic asepsis skills; e.g. hand-washing
- Identifying problems in the ordering and delivery of prophylactic antibiotics
- Improving performance on normothermia goals
- Standardizing skin prep solutions and techniques

In pursuit of these strategies, the team has worked with staff to identify differences in skin prep technique and worked to standardize practices; reduced number of prep solutions in regular use to the two solutions with the best prevention effectiveness profile; revamped procedure to get pre-op bath solutions to patients; improved the percent of patients prepping per protocol; changed vancomycin infusion procedure to improve pre-op delivery of antibiotic; and changed pre-operative bathing solution to HCG wipes based on evidence-based practice.

As next steps the team plans to:

- Continue work on reinforcing basics
- Encourage more physician engagement
- Get more data resources to allow drill down analyses and more real time data review
- Present to surgery department, orthopedics, and ICC
- Reinforce partnership with pharmacy for dissemination of peri-operative antibiotic dosing guidelines and re-dosing
- Initiate ongoing education program for patients and staff on pre-op and post-op infection prevention
- Begin antibiotics dosing based on patient weight
- Empower staff to monitor practices

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

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Alameda County Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION:

REPORTING ON THIS PROJECT: * Yes

Category 4: Hospital-Acquired Pressure Ulcer Prevention

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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Hospital-Acquired Pressure Ulcer Prevention

DY Total Computable Incentive Amount: * $ 1,875,500.00

Incentive Funding Already Received in DY: *

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

Numerator * 6.00

Denominator * 194.00

Prevalence (%) 0.03

Provide an in-depth description of milestone progress. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):
Put in data from nhsn website; baseline period

Data as reported to CALNOC website:
Reporting period: Jul. 1 2011 through Dec. 31, 2011. 6 patients had stage II, III, IV or unstageable pressure ulcers. 194 patients were surveyed.

DY Target (from the DPH system plan) *

% Achievement of Target N/A

Achievement Value 0.50

Category 4: Hospital-Acquired Pressure Ulcer Prevention

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

(insert milestone)

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

By 12/31/2011, ACMC provided SNI with a progress report detailing our harm reduction team activities and the improvement projects we are engaged in. We are participating in quarterly CALNOC surveys and are sharing this data with SNI. We have also applied to and been accepted as a full member of CALNOC. Data from Jul 2009-Dec 2009 has been submitted to SNI for benchmarking.

The interdisciplinary HAPU harm reduction team met regularly throughout 2011. Strategies have included:
- Reminding nurses of Time to Turn
- Improving beds
- Improving moisture management
- Improving coordination between nurses, physicians and physical therapy

In pursuit of these strategies, the team has conducted a Back-to-Basics program that reemphasized the basics of pressure ulcer prevention; added sling use to education at skills fair; purchased 138 new pressure guard mattresses; procured 3 pillows for every bed to assist positioning; and made dramatic improvements in over bed lighting to allow nurses to see skin better.

As next steps the team plans to:
- Purchase appropriate chairs for all patient rooms to encourage patient transfer by floor staff
- Purchase bedside commodes that accommodate both bariatric and patients of average size
- Develop protocol and training for use of the new equipment
- Track and implement new lift team legislation
- Continue to reinforce turning basics on the floors
- Automatic alerts on new electronic medical record
- Create graphs of both unavoidable and avoidable pressure ulcers

Over the period from July 2010 through Dec 2011, the HAPU harm reduction team reached or exceeded their goal of reducing incidence from a baseline of 3 per month to 2 or fewer per month for 4 of the 6 months from July – Dec 2011. They also report a new ability to solve problems with equipment/materials due to multidisciplinary teamwork.

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