

DSRIP Semi-Annual Reporting Form

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

* DPH SYSTEM:	Alameda County Medical Center
* REPORTING YEAR:	DY 7
* DATE OF SUBMISSION:	3/22/2013

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	\$ 612,468.75
Enhance Interpretation Services and Culturally Competent Care	\$ -
Collect Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities	\$ -
Enhance Urgent Medical Advice	\$ -
Introduce Telemedicine	\$ -
Enhance Coding and Documentation for Quality Data	\$ -
Develop Risk Stratification Capabilities/Functionalities	\$ -
Expand Specialty Care Capacity	\$ -
Enhance Performance Improvement and Reporting Capacity	\$ -
TOTAL CATEGORY 1 INCENTIVE PAYMENT:	\$ 612,468.75
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	\$ -
Implement/Expand Care Transitions Programs	\$ -
Implement Real-Time Hospital-Acquired Infections (HAIs) System	\$ -
TOTAL CATEGORY 2 INCENTIVE PAYMENT:	\$ -
Category 3 Domains	
Patient/Care Giver Experience (required)	\$ -
Care Coordination (required)	\$ -
Preventive Health (required)	\$ -
At-Risk Populations (required)	\$ -
TOTAL CATEGORY 3 INCENTIVE PAYMENT:	\$ -
Category 4 Interventions	
Severe Sepsis Detection and Management (required)	\$ -
Central Line Associated Blood Stream Infection Prevention (required)	\$ -
Surgical Site Infection Prevention	\$ -
Hospital-Acquired Pressure Ulcer Prevention	\$ -
Stroke Management	\$ -
Venous Thromboembolism (VTE) Prevention and Treatment	\$ -
Falls with Injury Prevention	\$ -
TOTAL CATEGORY 4 INCENTIVE PAYMENT:	\$ -
TOTAL INCENTIVE PAYMENT	\$ 612,468.75

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

A. ACMC's broad delivery system reform goals

In the DSRIP proposal submitted in February 2010, ACMC identified these over-arching system challenges:

- Inadequate infrastructure and capacity for both primary care and specialty care
- Fragmented, non-coordinated care within the disparate parts of our delivery system
- Excess reliance on episodic, physician encounters for managing chronic diseases in socially and medically complex populations
- Inefficient internal processes and work flows
- Insufficient attention to the patient's voice and experience
- Lack of focus on clinical outcomes
- Incomplete spread of established best practices in safety

And we set these **broad delivery system reform goals**:

1. **Move from a disease-focused model of episodic care** that is often initiated in response to acute medical conditions, **to a model of coordinated, pro-active care** that helps patients manage their own conditions.
2. Put **patients and their families at the center of their own care**, rather than at the periphery.
3. Enable patients to have **easy access to the appropriate levels of care**, rather than resorting to higher cost and temporary care in the emergency department.
4. **To provide the best care we know how to give, for every patient, at every site, every day.**

Looking back at our DY7 activities and accomplishments, it has been a year of preparing the ground and sowing seeds, with some early harvesting. There is still much work ahead to cultivate and tend these projects in years 8, 9 and 10; we look forward to realizing major system-level changes by 2015.

B. Summary of ACMC DY7 DSRIP Activities

For purposes of implementation, ACMC organized our DSRIP projects into 5 "buckets" which are slightly different than the four DSRIP categories. The project numbers refer to the original four DSRIP categories:

Ambulatory Care Services & Medical Homes	Project 1.1: Expand Primary Care Capacity Project 1.2: Implement and Utilize Disease Management Registry Functionality Project 1.3: Expand Specialty Care Capacity Project 2.1: Expand Medical Homes Project 2.2: Expand Care Management Models
Acute Care Services & Care Transitions	Project 2.3: Patient Experience Project 2.4: ED Flow Project 2.5: Care Transitions
Population Health (Category 3)	Project 3.1: Improve Patient/Caregiver Experience Project 3.2: Improve Care Coordination/Ambulatory Care Sensitive Conditions Project 3.3: Increase Utilization of Preventative Health Measures Project 3.4: Improve Clinical Outcomes for At-Risk Populations
Harm Reduction (Category 4)	Project 4.1: Sepsis Project 4.2: CLABSI Project 4.3: SSI Project 4.4: HAPU
Improvement Infrastructure	Project 1.4: Improve Organizational Infrastructure for Performance Improvement and Reporting

1. Over-all impact of DSRIP program

Effectiveness of Incentives

DSRIP has been a powerful tool to maintain focus on the broad system reform goals, and there is no doubt that the incentive structure of DSRIP has accelerated progress. Certainly the fact that significant dollars are associated with the milestones is a critical part of this. Beyond the dollars, however, the knowledge that there is a state and national focus on our performance, the partnership with other public hospitals, and the concreteness of the milestones has been a driver for change.

The impact of DSRIP is not limited to the specific milestones; each project is a lever to move us toward a larger goal. For instance, our DSRIP patient experience project is focused on improving nursing communication, but we have established a Patient and Family-Centered Care program, and set substantial improvement goals for patient experience across the system.

In practical terms, the DSRIP program led to the establishment of an accountability structure that included an executive-level oversight committee, category and project leads, and regular reporting calendar that has helped to maintain focus on accomplishing the milestones. Regular data reporting is built into the process.

Thinking like a System

We see small but promising signs that a change in culture is beginning. More projects –DSRIP and others—have cross-campus and/or cross-department participation. Looking for connections between different parts of the system is becoming more automatic. The relationships that develop through the project teams lead to future formal and informal collaborative efforts. This begins to establish the warp and weft of the seamless system of care that we envision.

Examples of system-spanning projects include:

- Solutions to emergency department (ED) overflow that include coordination by the ED, the inpatient service, and the rehabilitation program at the Fairmont campus;
- Our Reducing Readmissions plan that encompasses multiple DSRIP projects, including Care Transitions, Expanding the Medical Home, ED Flow, and the Complex Care Clinic (the HOPE Center) and reaches outside of the APMC system to link with our community partners.
- The community-wide Clinical Implementation work group which is developing a common care transitions protocol. The County Health Care Services Agency is sponsoring this effort, with strong representation from APMC's acute, ambulatory and administrative departments, as well as the Community Health Center Network and the Alliance (our Medi-Cal Managed Care organization).

While these efforts are not solely attributable to DSRIP, the incentive structure and focus provided by DSRIP has helped to advance them further and faster than would otherwise have been possible.

Data Focus

With its emphasis on measureable results, DSRIP has sharpened the focus on regular use of valid data to guide improvements and measure success. We are continually challenged to clearly define numerators and denominators, develop reliable methods for gathering and validating the data, and report and analyze the results. While we still have a lot of opportunity to improve in this area, there has been steady increase in the use of data to reach specific, measureable results throughout DY7.

Lessons Learned

We have found these key principles have helped to make DSRIP a tool for transformation and not just a revenue stream:

- Align DSRIP projects and activities with organizational strategic goals;
- Incorporate DSRIP milestones into bigger projects and use the DSRIP spotlight to advance those aims;
- Leverage DSRIP to coordinate change on multiple inter-linking fronts (e.g., ED Flow is dependent on inpatient flow, is dependent on improving discharge, is dependent on care transitions, is dependent on improving access to primary care);
- Use DSRIP funds for investment in transformation and sustainable growth.

2. Ambulatory Care Services

Brief Summary of DY7 (FY 2011/12) Results

Project 1.1: Expand Primary Care Capacity

Primary Care visits in Newark Health Center increased by more than 5% over the 2010 baseline. Plans were made and initiated to expand primary care capacity in Oakland by 15% by DY10. Existing clinic sites added exam rooms and hired additional primary care providers and supporting staff to provide care in the expanded space. Plans were made to establish a 24/7 Nurse Advice Line for all APMC primary care clinics.

Project 1.2: Implement and Utilize Disease Management Registry Functionality

Panel management, with support of an electronic disease management registry, is now active at all ACMC primary care clinics; panel managers were hired, and clinicians and staff were trained. Panels for participating providers were reviewed and corrected for accurate patient assignment and diabetes diagnosis.

Project 1.3: Expand Specialty Care Capacity

Optometry encounters more than doubled, and ACMC developed and began implementing plans to increase cardiology, dermatology, and orthopedic encounters. Expansions of service have already led to reductions in backlogs and increases in encounters in these three specialties (orthopedics and cardiology each increased by 22%, and dermatology by 6%).

Project 2.1: Expand Medical Homes

A “Connecting to Care” plan was developed for linking high priority patients to a medical home. The work plan lays out detailed steps needed to accomplish our goal of providing high priority patients in the emergency department (ED) and specialty care clinics with a medical home assignment and an appointment to be seen within 60 days of referral by DY10.

Project 2.2: Expand Care Management Models

Two clinics were established, Hepatitis C and Pain, in which multidisciplinary teams provide coordinated care to patients with complex needs, and a retrospective utilization and financial analysis was performed that will be a baseline for future analysis. Plans were developed to launch the HOPE Center, a program that will provide intensive, coordinated care management to patients with highly complex medical/behavioral/social conditions.

Impact on Broad Delivery System Reform

The panel management program, with the accompanying enhanced functionality of the electronic disease registry, is critical infrastructure for all of our system reform goals (coordinated, pro-active, patient-centered, appropriate and high quality care). The panel managers use the disease registry to pro-actively identify gaps in care, and they work closely with the clinical team to provide the needed care, and patient education, in order to prevent acute episodes that can be avoided. Full realization of the benefits of the panel management model will depend on our success in increasing primary care capacity and linking priority patients to a medical home, which are on-going projects for DY8-10. This year’s expansion of specialty care and complex care management clinics has improved access to appropriate levels of care; more expansion is planned.

The motivation provided by the DSRIP milestones has helped us to rise above the “tyranny of the urgent” to address larger system goals such as developing the medical home model. The milestones are requiring us to grapple with challenging questions about how best to organize care for people at high risk, such as those with chronic disease and hospital readmissions, in an environment in which access to primary care will likely continue to be less than is needed. This work will be on-going as we strive to connect patients who are most in need of regular care to medical homes.

Of course, just having the additional funding makes a big difference. For instance, some of our DSRIP revenue has gone to fund a pilot program that places Ambulatory Care staff in the ED as “ED Navigators”. This relatively inexpensive intervention (the navigator role can be filled by a non-licensed healthcare worker) is making it possible to identify a patient’s existing primary care provider, if any, and re-connect the patient to that provider, whether at ACMC or in the community. The ED navigator enhances continuity of care, makes more efficient use of ACMC’s limited primary care resources, and contributes to our system reform goals of patient-centered care and access to appropriate levels of care. The inpatient service is considering adapting a similar navigator model to achieve the same aims for patients who are hospitalized – an example of cross-fertilization that is another sign of the increased “system-ness” that we are beginning to see.

This story also illustrates the point that DSRIP is helping us to make the connections across the parts of the system. The medical home manager and the call center director are using the disease registry to identify and track the high risk patients and ensure they are connected to a medical home. This also makes it possible for the panel management coordinators to follow up on their care, if they are at an ACMC medical home.

With the ED Navigator and the Medical Home “Connecting to Care” projects, there is a new level of attention to helping patients to access care in a setting that will be more able to provide coordinated, preventive care, rather than the acute and episodic care that has too often been the norm.

3. Acute Care Services

Brief Summary of DY7 (FY 2011/12) Results

Project 2.3: Patient Experience

This year ACMC adopted the StuderGroup's Evidence-Based Learning model, in particular the AIDET (Acknowledge, Introduce, Duration, Explanation and Thank You) model for improving nurse to patient communication. With the development of a comprehensive training curriculum and education plan to disseminate the model, training began for managers and all inpatient permanent nursing staff, with self-evaluations and observational assessments to reinforce the newly adopted model. In addition, a new position, Director of Patient and Family-Centered Care, was created and filled. The Patient Experience Transformation (PEXT) collaborative is described in the Shared Learning section.

Project 2.4: ED Flow

The ED conducted several process improvement projects aimed at reducing the length of stay. These improvements have resulted in a 19% reduction in the overall average length of stay for low acuity patients; however, length of stay for admitted patients has not yet improved. This will be a major focus of work in DY8.

Project 2.5: Care Transitions

The Patient Call Manager program, through which nurses call all discharged patients by phone within 24-72 hours after discharge, has been fully implemented across all acute care units. ACMC developed a reducing readmissions plan that builds on several DSRIP projects to address the system goal of having coordinated care transitions, to better enable patients to care for themselves and to avoid preventable readmissions. We were awarded a grant from the Gordon and Betty Moore Foundation to fund a high-risk Care Transitions Team that will provide coordinated care management and education during and immediately after discharge to ensure solid linkage to post-discharge care for patients who are at especially high risk for readmissions. This program is beginning in DY8.

Impact on Broad Delivery System Reform

A principle we have used to maximize the impact of DSRIP on system change is to use a specific DSRIP milestone as a measure for a larger project, and then use the DSRIP spotlight to sharpen the focus on that project. Patient experience is a good example of this. The DSRIP patient experience milestone is focused on nursing communication. This is of course important in itself, because nursing care is so fundamental to the overall patient experience. However, our DSRIP patient experience milestone is just one part of a much larger effort that is underway at ACMC. The AIDET model is being spread throughout the system, not just among nurses. A Patient and Family Advisory Council has been established, and a position for Director of Patient and Family-Centered Care was created and filled. This new leader, who started in June 2012, is responsible for developing and leading the implementation of a Patient and Family-Centered Care model throughout ACMC. Success will be measured in part by the improvement of patient experience ratings for our overall healthcare system.

The changes stimulated by DSRIP in the area of care transitions and patient flow are another example of this principle. Adopting a patient-centered approach naturally leads to assessing patient flow and care transitions. How does the patient move from one part of the system to another? Are we providing smooth pathways from one set of providers to another, or are patients facing obstacles and frustrations, inefficiencies and dangers along the way? When we start to pay attention to flow, we begin to think as a system. As a result of the Care Transitions project, we see hopeful signs that the culture of the acute care hospital is beginning to change orientation, from sole focus on the inpatient episode and discharge to continuity and care transitions.

Multiple initiatives, not limited to DSRIP, are contributing to a change in care transitions processes. The Patient Call Manager, Lean projects, ED Flow, and the medical home milestone are all related, and they are increasingly being melded into a single aligned effort. DSRIP funds were leveraged to win a significant grant from the Gordon and Betty Moore Foundation, the goal of which is to reduce preventable 30 day readmissions. In turn, DSRIP funds have been tapped to fund a Reducing Readmissions coordinator and to add a pharmacist to the High Risk Care Transitions Team primarily funded by the Moore grant.

4. Category 3: Improvements in Population Health

Brief Summary of DY7 (FY 2011/12) Results

ACMC generated reports on the four Category 3 domains: patient/care-giver experience, care coordination, preventive health and at-risk populations. For the patient / care-giver experience, a contract was initiated with Press-Ganey to generate ambulatory care patient experience data according to the DSRIP protocol. For the other three domains, a team met over the course of several months to review the measures and the available data sources to determine the most effective means to report the data. Trial reports were generated and were reviewed by the group. Further testing and refinements of the report were made until the group was satisfied that we had the most accurate report possible.

Impact on Broad Delivery System Reform

The first step on the path to improvement is reporting and understanding data. The process of developing data reports is beneficial in itself, as through this process we are able to understand the data systems that are available to us, identify weaknesses and begin to strategize how to improve them. Since ACMC is in the middle of implementing a new electronic health record (EHR), the process of developing the DSRIP reports has been useful for developing and testing the reporting functionality of the EHR. Next year some of the data will come from the new EHR which will offer more power for analyzing and using the data for improvement.

Reporting on the Category 3 population health measures contributes to the goals of moving from a disease-focused model to coordinated preventive care, and also adds to the growth of a culture of data-guided quality improvement at ACMC. As with DSRIP in general, the high stakes and high visibility heightens the attention paid to the Category 3 data. These data have been reported to the Quality Council and will be used by the Ambulatory Care quality committees as well. We will continue to work to improve, refine and validate these data as time goes on.

The panel management program, which is one of our DSRIP milestones, is a primary strategy for improvements in population health at ACMC. The panel management coordinators use the data provided by i2i Tracks, our disease management registry, to identify and address care gaps for patients who are coming in for an appointment and to outreach to patients, for instance to get labs done before their appointment. Panel management coordinators actively monitor all diabetes cases and prompt physicians when tests or other interventions are due, such as flu vaccine and/or breast cancer screening.

5. Category 4: Urgent Improvements in Quality and Safety

Brief Summary of DY7 (FY 2011/12) Results

Project 4.1: Sepsis

ACMC has reported data to the Safety Net Institute and the State of California on sepsis mortality and sepsis bundle compliance. An interdisciplinary harm reduction team has worked actively to reduce sepsis mortality and increase use of the sepsis bundle. 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, and speeding up access to appropriate antibiotics.

Project 4.2: Central Line-Associated Blood Stream Infections (CLABSI)

ACMC has reported data to the Safety Net Institute and the State of California on CLABSI and Central Line Insertion Practices (CLIP) compliance. An interdisciplinary harm reduction team has worked actively to reduce CLABSI and increase use of CLIP. Some strategies have included: Standardizing documentation to include reminders of critical prevention elements of care; standardizing protocols for inserting and maintaining central lines and associated dressings; switching to newer equipment; integrating the rapid response team into routine "handoffs" of high risk patients; improving staff education and monitoring of compliance.

Project 4.3: Surgical Site Infections (SSI)

ACMC has reported data to the Safety Net Institute and the State of California on four surgical site infections. An interdisciplinary harm reduction team worked actively in the first half of the year to reduce surgical site infections; due to staff turnover the team did not meet regularly in the second half of the year. Some strategies included: monitoring and reinforcing adherence to basic asepsis skills; e.g. hand-washing; identifying and addressing problems in the ordering and delivery of prophylactic antibiotics; improving performance on normothermia goals; standardizing skin prep solutions and techniques.

Project 4.4: Hospital Acquired Pressure Ulcers (HAPU)

ACMC has reported data to the Safety Net Institute and the State of California on HAPU prevalence. An interdisciplinary harm reduction team worked actively in the first half of the year to reduce HAPUs; due to staff turnover the team did not meet regularly in the second half of the year. Improvements made included installation of new pressure-guard mattresses and pillows to assist with positioning, and initiation of "back to basics" training for bedside nurses. An in-depth assessment of current processes and gaps related to identification, management and reporting of pressure ulcers began in the second half of DY7.

Impact on Broad Delivery System Reform

A major challenge at ACMC is standardizing processes and sustaining results. In the current environment of transformation in healthcare, there are so many competing priorities; it is hard to stay focused. DSRIP is supporting the system reform goal of standardizing processes for patient safety and quality. The fact that DSRIP is a five-year program, that we are only paid if we produce measureable reductions in harm, together with the knowledge that our fellow public healthcare systems are working on the same measures lends structure and leads to sustained attention to these priorities.

The Harm Reduction Team model of multidisciplinary teams composed of the full range of people involved encourages the broad system goal of reducing fragmentation, crossing silos and creating a coordinated system of high quality care. Starting in July 2010 through December 2011, ACMC conducted a focused Harm Reduction campaign, which was supported by a team of outside consultants in addition to the quality department. As part of this campaign, all of our Category 4 target areas had active interdisciplinary harm reduction teams that made tests of change and measured results.

The Harm Reduction campaign included several other teams in addition to the four DSRIP projects. These teams are also contributing to the system goal of providing the best care we know how to give, for every patient, at every site, every day. All of the harm reduction teams were invited to make proposals to use DSRIP funds to advance harm reduction and patient safety. In one example, DSRIP contributed to a 50% reduction in seclusions and restraints, and a significant reduction in assaults, at our psychiatric inpatient service, by funding therapeutic and recreational equipment and activities for patients. DSRIP funds also made possible the purchase of new mattresses to reduce risk of hospital-acquired pressure ulcers, enhanced staffing support for quality improvement teams, and additional clinical expertise in Sepsis and CLABSI to drive changes in daily practice.

6. Improvement Infrastructure

Brief Summary of DY7 (FY 2011/12) Results

Project 1.4: Improve Organizational Infrastructure for Performance Improvement and Reporting

In DY7, ACMC established the System Transformation Center (STC) to assist in achieving and sustaining the system transformations ACMC needs to make in order to succeed under health reform. STC staff was hired, oversight and accountability structures were established and a four-year work plan was adopted. The Lean/Six-Sigma training initiative was launched; an infrastructure was established that includes a Kaizen Project Office (KPO), a dedicated KPO director, an event coordinator, and a post-event follow-up coordinator. From January to June, seventeen separate events, many of them lasting 4-5 days, were organized and delivered by the KPO.

Impact on Broad Delivery System Reform

ACMC is investing in the System Transformation Center in order to support us in becoming the coordinated, efficient and high quality health system we have envisioned. The STC is key to achieving and sustaining the DSRIP delivery system reform goals.

As the STC has launched and is beginning to have an impact, it is exciting to observe the beginnings of a culture shift. The STC is developing formal structures for prioritizing, project planning and management, and alignment. Through the STC, we are building organizational capacity in these areas, which will help address many of the system challenges identified in our DSRIP proposal, such as fragmented, non-coordinated care within the disparate parts of our delivery system; inefficient internal processes and work flows; and incomplete spread of established best practices in safety.

In the absence of a strong incentive like that provided by DSRIP, the inertia of the system is to maintain silos. Often we are so busy accomplishing the work in front of us that we aren't even aware of work going on in other parts of the system that might be related. We miss potential efficiencies and synergies; and when the different parts of the system are not integrated, we certainly are not "patient-centered."

The DSRIP milestones are pulling ACMC in the direction of alignment and synergy. Because the milestones are interdependent, project leads need to work together and coordinate—and during DY7 the STC has fostered these linkages by, for instance, introducing key players, building teams, and showing how success in one project can be enhanced by working with another.

The Lean Kaizen Project Office is part of the STC and is training dozens of staff and building an infrastructure for organized process improvement. The Lean program is providing the tools clinical and administrative leaders need to analyze and improve processes as an on-going part of their work. We are beginning to change the culture of "whatever works" to a culture that supports standardized and planned work processes.

The STC is creating a Project Portfolio and Management Office and a Change Bureau to be a central clearinghouse where all significant projects, whether DSRIP-related or not, will be prioritized and planned (including business analysis, resource allocation, execution strategies, etc.) before launching. Project leaders will receive project and business development support, learn how to use common project management tools, prioritize projects to align with ACMC's strategic plan and get coaching to prospectively identify resource needs, realistic time frames, etc. It sounds simple, but ACMC, as is true of most public health systems, often has not had the basic administrative and organizational supports such as data analysis, business intelligence, project management and team support that are necessary for successful project implementation. With the STC, we aim to embed these supports into the organizational infrastructure, to enable us to **provide the best care we know how to give, for every patient, at every site, every day.**

Summary of DPH System's Participation in Shared Learning

7. Shared Learning

[1]

Title: Avoiding Readmission through Collaboration (ARC)

Sponsor: Center for Quality System Improvement and the California Quality Collaborative – Funded by the Gordon and Betty Moore Foundation

Dates of Participation: 2010-present

Participants: Physicians, nurses, administrators and others from ambulatory care, the inpatient service, patient registration, and the quality department

Goals & Activities:

- Goal: to reduce 30 and 90 day all cause readmission rates by 30% by December 2013
- Activities: the team conducted chart reviews, administered key informant questionnaires from staff and patients and analyzed ACMC data on readmissions. We also participated in learning sessions and reviewed literature.

Highlights & Results:

- A comprehensive plan for reducing readmissions was developed and adopted
- The Project RED model for implementation at ACMC's Highland Hospital was adopted
- Gordon and Betty Moore Foundation grant proposal was submitted and funded in June 2012
- At the June ARC Learning session, the ACMC team presented a Resident Toolkit developed by the team

[2]

Title: CHCF Healthcare Leadership Program

Sponsor: California HealthCare Foundation

Dates of Participation: December 2010 - 2012

Participants: Three leaders from ACMC participated as Class of 2010-2012 Fellows

Goals & Activities:

- To teach leaders to be effective change agents within healthcare delivery system
- Each fellow has to do a healthcare improvement project as a final "thesis" in order to graduate

Highlights & Results:

- Researched and began the preliminary phases of opening a complex care clinic at ACMC called the HOPE (Highland Out-Patient Enhancement) Center.
- Assessed the impact of health coaches on readmission rate for patients with heart failure and found that the team-based model of care in the heart failure clinic resulted in a great reduction in readmission rates for patients who actually came to clinic
- ACMC is now more able to effectively manage change and improvement efforts within the organization through leadership skills regarding people, purpose, and processes

[3]

Title: Sepsis & CLABSI Collaborative

Sponsor: Safety Net Institute

Dates of Participation: Participation from July 2011 to present

Participants: At least 20 staff, including Quality Analysts, Physicians, Nurses, Director of Quality Improvement, Clinical Quality Project Assistant, and Nurse Educator

Goals & Activities:

- Participated in learning sessions with expert faculty focused on data issues, implementing the CLABSI bundle, and trainings on performance improvement techniques
- Monthly webinars on specific topics

Highlights & Results:

- Data reported to SNI is aggregated and reported back to members for benchmarking and to drive quality improvement
- Best practices and information regarding data reporting is and discussed among collaborative members
- ACMC attended and presented at the SNI Sepsis & Collaborative Learning Session #3 on August 15th, 2012

Summary of DPH System's Participation in Shared Learning

[4]

Title: Patient Experience Transformation (PEXT)

Sponsor: Safety Net Institute in partnership with ExperiaHealth

Dates of Participation: October 2011 – June 2012

Participants: Safety Coordinator, Patient Affairs Officer, Director of Respiratory Services, Assistant Director of Nursing, Medical Director of Patient Experience and Equity, and Organization Development Staff

Goals & Activities:

- Goal: To achieve measurable advances in the patient and caregiver experience.
- Activities: The team collected data through focus group interviews, and analyzed the data at a PExT Experience Design Workshop.

Highlights & Results: From their research, the PExT team chose three solutions to prioritize based on urgency of need within the sphere of the Nursing department. The three solutions were 1) developing a patient orientation to the unit upon admission; 2) finding creative ways to educate patients in house; 3) using technology (electronic order tracking, translation apps, call light systems, nurse telephones, etc.).

[5]

Title: End-of-Life Nursing Education Consortium (ELNEC) Public Hospital Project

Sponsor: California Healthcare Foundation in collaboration with the Safety Net Institute and UCSF's Palliative Care Leadership Center

Dates of Participation: November 2011 - Present

Participants: APMC Nurses, Physicians, Mid-Level Practitioners

Goals & Activities:

- Participation 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
- Two full-day training courses to nurses, nurse-assistants, and social workers that included an introduction to Palliative Care and Pain Management, and presentations on symptom management, care for the imminently dying, and grief, loss and bereavement. Activities included presentations, group exercises, videos and role plays
- Training courses in 'Care for the Imminently Dying' and 'Palliative Care and Pain Management'
- Initiated Hospice Education Network (HEN) page on APMC intranet
- Participated in monthly calls with other public hospitals as part of the ELNEC learning collaborative

Highlights & Results:

- Completing pages on Palliative Care and the Physicians Orders for Life Sustaining Treatment (POLST) form for the hospital admissions binder
- Meeting with Hospice partners and collaborating on the development of a discharge checklist to help streamline our discharges from the hospital to "home with hospice" or "nursing home with hospice" so there are no lapses in crucial medicines provided to those patients
- Developing a new electronic code status and life-sustaining treatment orders that mirrors the POLST form

[6]

Title: Just Culture Certification Course

Sponsor: The Just Culture Community

Dates of Participation: December, 2011

Participants: 4 APMC employees attended, including the Chief Nursing Executive and the Vice President of Quality

Goals & Activities: To have certified trainers in Just Culture with the expectation of incorporating Just Culture concepts into the APMC employee engagement, risk and regulatory process.

Highlights & Results:

- Assisted attendees in identifying system issues versus personnel issues and contributed to a more effective investment in our employees while properly addressing process breaches
- APMC is now analyzing process breaches differently, investing in coaching and educating our staff and holding staff more accountable for high risk behaviors

Summary of DPH System's Participation in Shared Learning

[7]

Title: NAPH Fellowship

Sponsor: National Association of Public Hospitals

Dates of Participation: June 2012- May 2013

Participants: Chief Nurse Executive, Director of Utilization Management, Director of Nursing and Clinical Education, Assistant Director of Nursing, and the Division Chief of Inpatient Medicine

Goals & Activities: A three-session interactive learning experience designed to equip senior clinicians and managers with tools to boost care efficiency within their organizations

Highlights & Results:

- A collaborative performance improvement project at ACMC with a focus on interdisciplinary communication has started. It will focus specifically on interdisciplinary daily rounding for improving the discharge process
- 2012 NAPH Fellows from ACMC attended 2 week-long sessions in San Francisco and Rhode Island during June and October respectively.

[8]

Title: HOPE Center Charrette

Sponsor: ACMC System Transformation Center

Dates of Participation: June 18th, 2012

Participants: Members of the HOPE Center steering committee, administrative and clinical leaders from ACMC, complex care experts, and colleagues from regional public hospitals and safety net organizations

Goals & Activities:

- To gather answers to specific design questions of the complex care center
- To understand what is known about the complex care clinic model and gather expert opinions concerning so far unanswered questions about the care of complex patients
- To harvest the ideas, knowledge, and experiences of community members, and leaders in various stages of developing complex care centers, so that our collective knowledge can be used to direct design the evaluation of these programs in our region and nationwide

Highlights & Results:

- Discussed best practices and models of care in care management clinics with both regional and national experts in a setting that was informal and included key leadership at Alameda County medical center
- Newly hired leadership of the complex care management clinic was given the opportunity to meet both key members of ACMC staff as well as community-based organizations with which they will interact
- Came to further understand the intersecting perspectives and interests of regional and national experts, community groups, and leadership of ACMC through structured small group discussions

[9]

Title: Healthcare Quality and Equity Action Forum

Sponsor: Disparities Solutions Center, Massachusetts General Hospital

Dates of Participation: Preparation during FY2011/12 for forum on September 24-25, 2012

Participants: ACMC Quality Analyst

Goals & Activities:

- Goal: To network with and hear from leaders who are building the foundation for high-performing healthcare systems, accountable care organizations, and patient-centered medical homes to deliver high quality, equitable health care to diverse populations
- Activity: Designed a workshop, "Digging Deep into Disparities Dashboards: Perspectives from the Field"

Highlights & Results:

- Attained a better understanding of the role of Health Equity in Healthcare Reform, Patient and Family-Centered Care, and Value Based Purchasing
- Learned about other systems' targeted interventions to improve outcomes for vulnerable patients with chronic disease management
- Quality and experience and population management metrics can now be stratified by measures of vulnerability to determine where interventions are required.

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
 DPH SYSTEM: Alameda County Medical Center
 REPORTING YEAR: DY 7
 DATE OF SUBMISSION: 9/29/2012

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:	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.
<i>Achievement Value</i>	1.05
<i>Achievement Value</i>	1.00
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
<i>Achievement Value</i>	Yes
<i>Achievement Value</i>	1.00
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.
<i>Achievement Value</i>	Yes
<i>Achievement Value</i>	1.00
DY Total Computable Incentive Amount:	\$ 4,899,750.00
Total Sum of Achievement Values:	3.00
Total Number of Milestones:	3.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	\$ 4,899,750.00
Incentive Funding Already Received in DY:	\$ 4,899,750.00
<u>Incentive Payment Amount:</u>	\$ -

DSRIP Semi-Annual Reporting Form

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.	0.82
<i>Achievement Value</i>		1.00
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.	1.00
<i>Achievement Value</i>		1.00
DY Total Computable Incentive Amount:		\$ 4,899,750.00
Total Sum of Achievement Values:		2.00
Total Number of Milestones:		2.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		\$ 4,899,750.00
Incentive Funding Already Received in DY:		\$ 4,287,281.25
<u>Incentive Payment Amount:</u>		\$ 612,468.75

DSRIP Semi-Annual Reporting Form

Category 1 Summary Page

Expand Specialty Care Capacity

Process Milestone:	Increase optometry encounters by 20% compared to baseline (ACMC FY 2010). Metric: Encounter data for baseline and demonstration year.	2.27
<i>Achievement Value</i>		1.00
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.	Yes
<i>Achievement Value</i>		1.00
DY Total Computable Incentive Amount:		\$ 4,899,750.00
Total Sum of Achievement Values:		2.00
Total Number of Milestones:		2.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		\$ 4,899,750.00
Incentive Funding Already Received in DY:		\$ 4,899,750.00
<u>Incentive Payment Amount:</u>		\$ -

DSRIP Semi-Annual Reporting Form

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.	Yes
Achievement Value		1.00
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:		3.00
Total Number of Milestones:		3.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		\$ 4,899,750.00
Incentive Funding Already Received in DY:		\$ 4,899,750.00
<u>Incentive Payment Amount:</u>		\$ -

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
 DPH SYSTEM: Alameda County Medical Center
 REPORTING YEAR: DY 7
 DATE OF SUBMISSION: 9/29/2012

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 %.
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- The red boxes indicate Total Sums.

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.
Achievement Value	<div style="border: 1px solid black; width: 100px; height: 100px; margin: 0 auto; display: flex; align-items: center; justify-content: center;">Yes</div>
DY Total Computable Incentive Amount:	<div style="border: 1px solid red; padding: 2px;">\$ 3,920,000.00</div>
Total Sum of Achievement Values:	<div style="border: 1px solid red; padding: 2px;">1.00</div>
Total Number of Milestones:	<div style="border: 1px solid red; padding: 2px;">1.00</div>
Achievement Value Percentage:	<div style="border: 1px solid red; padding: 2px;">100%</div>
Eligible Incentive Funding Amount:	<div style="border: 1px solid red; padding: 2px;">\$ 3,920,000.00</div>
Incentive Funding Already Received in DY:	<div style="border: 1px solid red; padding: 2px;">\$ 3,920,000.00</div>
<u>Incentive Payment Amount:</u>	<div style="border: 1px solid red; padding: 2px;">\$ -</div>

DSRIP Semi-Annual Reporting Form

Category 2 Summary Page

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.	Yes
<i>Achievement Value</i>		1.00
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.	Yes
<i>Achievement Value</i>		1.00
DY Total Computable Incentive Amount:		\$ 3,920,000.00
Total Sum of Achievement Values:		2.00
Total Number of Milestones:		2.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		\$ 3,920,000.00
Incentive Funding Already Received in DY:		\$ 3,920,000.00
<u>Incentive Payment Amount:</u>		\$ -

DSRIP Semi-Annual Reporting Form

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.	Yes
<i>Achievement Value</i>		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:		\$ 3,920,000.00
<u>Incentive Payment Amount:</u>		\$ -

DSRIP Semi-Annual Reporting Form

Category 2 Summary Page

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.	Yes
<i>Achievement Value</i>		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:		\$ 3,920,000.00
<u>Incentive Payment Amount:</u>		\$ -

DSRIP Semi-Annual Reporting Form

Category 2 Summary Page

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:

\$ 3,920,000.00

Incentive Payment Amount:

\$ -

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
 DPH SYSTEM: Alameda County Medical Center
 REPORTING YEAR: DY 7
 DATE OF SUBMISSION: 9/29/2012

Category 3 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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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)	<input type="text" value="Yes"/>
Achievement Value	<input type="text" value="1.00"/>
Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme to the State (DY8-10)	<input type="text" value="N/A"/>
Achievement Value	<input type="text" value=""/>
Report results of CG CAHPS questions for "How Well Doctors Communicate With Patients" theme to the State (DY8-10)	<input type="text" value="N/A"/>
Achievement Value	<input type="text" value=""/>
Report results of CG CAHPS questions for "Helpful, Courteous, and Respectful Office Staff" theme to the State (DY8-10)	<input type="text" value="N/A"/>
Achievement Value	<input type="text" value=""/>
Report results of CG CAHPS questions for "Patients' Rating of the Doctor" theme to the State (DY8-10)	<input type="text" value="N/A"/>
Achievement Value	<input type="text" value=""/>
Report results of CG CAHPS questions for "Shared Decisionmaking" theme to the State (DY8-10)	<input type="text" value="N/A"/>
Achievement Value	<input type="text" value=""/>
DY Total Computable Incentive Amount:	<input type="text" value="\$ 3,324,750.00"/>
Total Sum of Achievement Values:	<input type="text" value="1.00"/>
Total Number of Milestones:	<input type="text" value="1.00"/>
Achievement Value Percentage:	<input type="text" value="100%"/>
Eligible Incentive Funding Amount:	<input type="text" value="\$ 3,324,750.00"/>
Incentive Funding Already Received in DY:	<input type="text" value="\$ 3,324,750.00"/>
<u>Incentive Payment Amount:</u>	<input type="text" value="\$ -"/>

DSRIP Semi-Annual Reporting Form

Category 3 Summary Page

Care Coordination (required)

Report results of the Diabetes, short-term complications measure to the State (DY7-10)	<input type="text" value="Yes"/>
<i>Achievement Value</i>	<input type="text" value="1.00"/>
Report results of the Uncontrolled Diabetes measure to the State (DY7-10)	<input type="text" value="Yes"/>
<i>Achievement Value</i>	<input type="text" value="1.00"/>
Report results of the Congestive Heart Failure measure to the State (DY8-10)	<input type="text" value="N/A"/>
<i>Achievement Value</i>	<input type="text"/>
Report results of the Chronic Obstructive Pulmonary Disease measure to the State (DY8-10)	<input type="text" value="N/A"/>
<i>Achievement Value</i>	<input type="text"/>
DY Total Computable Incentive Amount:	<input type="text" value="\$ 3,324,750.00"/>
Total Sum of Achievement Values:	<input type="text" value="2.00"/>
Total Number of Milestones:	<input type="text" value="2.00"/>
Achievement Value Percentage:	<input type="text" value="100%"/>
Eligible Incentive Funding Amount:	<input type="text" value="\$ 3,324,750.00"/>
Incentive Funding Already Received in DY:	<input type="text" value="\$ 3,324,750.00"/>
<u>Incentive Payment Amount:</u>	<input type="text" value="\$ -"/>

Preventive Health (required)

Report results of the Mammography Screening for Breast Cancer measure to the State (DY7-10)	<input type="text" value="Yes"/>
<i>Achievement Value</i>	<input type="text" value="1.00"/>
Reports results of the Influenza Immunization measure to the State (DY7-10)	<input type="text" value="Yes"/>
<i>Achievement Value</i>	<input type="text" value="1.00"/>
Report results of the Child Weight Screening measure to the State (DY8-10)	<input type="text" value="N/A"/>
<i>Achievement Value</i>	<input type="text"/>
Report results of the Pediatrics Body Mass Index (BMI) measure to the State (DY8-10)	<input type="text" value="N/A"/>
<i>Achievement Value</i>	<input type="text"/>
Report results of the Tobacco Cessation measure to the State (DY8-10)	<input type="text" value="N/A"/>
<i>Achievement Value</i>	<input type="text"/>
DY Total Computable Incentive Amount:	<input type="text" value="\$ 3,324,750.00"/>
Total Sum of Achievement Values:	<input type="text" value="2.00"/>
Total Number of Milestones:	<input type="text" value="2.00"/>
Achievement Value Percentage:	<input type="text" value="100%"/>
Eligible Incentive Funding Amount:	<input type="text" value="\$ 3,324,750.00"/>
Incentive Funding Already Received in DY:	<input type="text" value="\$ 3,324,750.00"/>
<u>Incentive Payment Amount:</u>	<input type="text" value="\$ -"/>

DSRIP Semi-Annual Reporting Form

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:

\$ 3,324,750.00

Total Sum of Achievement Values:

2.00

Total Number of Milestones:

2.00

Achievement Value Percentage:

100%

Eligible Incentive Funding Amount:

\$ 3,324,750.00

Incentive Funding Already Received in DY:

\$ 3,324,750.00

Incentive Payment Amount:

\$ -

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
 DPH SYSTEM: Alameda County Medical Center
 REPORTING YEAR: DY 7
 DATE OF SUBMISSION: 9/29/2012

Category 4 Summary Page

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Category 4 Interventions

Severe Sepsis Detection and Management (required)

Compliance with Sepsis Resuscitation bundle (%)	0.36
Achievement Value	1.00
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.	0.34
Achievement Value	1.00
DY Total Computable Incentive Amount:	\$ 1,875,500.00
Total Sum of Achievement Values:	3.00
Total Number of Milestones:	3.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	\$ 1,875,500.00
Incentive Funding Already Received in DY:	\$ 1,875,500.00
<u>Incentive Payment Amount:</u>	\$ -

DSRIP Semi-Annual Reporting Form

Category 4 Summary Page

Central Line Associated Blood Stream Infection Prevention (required)

Compliance with Central Line Insertion Practices (CLIP) (%)	0.99
<i>Achievement Value</i>	1.00
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
<i>Achievement Value</i>	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	0.99
<i>Achievement Value</i>	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.	0.00
<i>Achievement Value</i>	1.00
DY Total Computable Incentive Amount:	\$ 1,875,500.00
Total Sum of Achievement Values:	4.00
Total Number of Milestones:	4.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	\$ 1,875,500.00
Incentive Funding Already Received in DY:	\$ 1,875,500.00
<u>Incentive Payment Amount:</u>	\$ -

DSRIP Semi-Annual Reporting Form

Category 4 Summary Page

Surgical Site Infection Prevention

Rate of surgical site infection for Class 1 and 2 wounds (%)		0.056
<i>Achievement Value</i>		1.00
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.	Yes
<i>Achievement Value</i>		1.00
DY Total Computable Incentive Amount:		\$ 1,875,500.00
Total Sum of Achievement Values:		2.00
Total Number of Milestones:		2.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		\$ 1,875,500.00
Incentive Funding Already Received in DY:		\$ 1,875,500.00
<u>Incentive Payment Amount:</u>		\$ -

DSRIP Semi-Annual Reporting Form

Category 4 Summary Page

Hospital-Acquired Pressure Ulcer Prevention

Prevalence of Stage II, III, IV or unstagable pressure ulcers (%)	0.02
<i>Achievement Value</i>	1.00
Optional Milestone: Share data, promising practices, and findings with SNI to foster shared learning and benchmarking across the California public hospitals.	Yes
<i>Achievement Value</i>	1.00
DY Total Computable Incentive Amount:	\$ 1,875,500.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	2.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	\$ 1,875,500.00
Incentive Funding Already Received in DY:	\$ 1,875,500.00
<u>Incentive Payment Amount:</u>	\$ -

DSRIP Semi-Annual Reporting Form

Category 1: Expand Primary Care Capacity

To make sure the community was aware of the new services and renovated site, clinic leaders conducted a low-budget, high-personal-contact promotional campaign, going out to meet with stakeholders in the community. To help build the pediatric service, they made visits to local schools and met with the superintendent of schools. Teams went to small local markets to reach out to Spanish-speaking residents, and the clinic manager met with the Newark City Manager to enlist his support in promoting the clinic.

Although Newark did accomplish the DY7 milestone, there were some significant challenges in doing so, specifically construction delays and long lead times for filling positions for providers and support staff.

Ironically, even though there is great demand for access to primary care, we also have a fairly high no-show rate for appointments. This results in wasted appointments at the same time as there is unmet demand for care. We worked hard to ensure that every available appointment slot was utilized by actively managing slots and moving patients up on the schedule daily to allow for more drop-in and urgent patients. Additionally, we have tried multiple approaches to improve the show rate for appointments. Before our new processes were put in place, patients received an automated reminder call and an additional call from the eligibility clerk. To improve the show rate, staff made additional calls to ensure the patient would keep the appointment. If the patient told us that they were not coming, we worked hard to fill the vacant slot. For instance, we called patients with appointments in the future and asking if they would like to come in early. We diligently rescheduled patients who missed appointments.

ACMC distributes a "daily dashboard" of statistics such as visit volume, hospital census, etc. The clinic manager monitored this data carefully to assess performance.

The experiences in expanding services at Newark will inform future planned expansions. We have learned how challenging ramp-up can be due to factors such as delays in construction and the difficulty of hiring new providers. We see the need for improved planning and assessment of market forces; we look forward to the new System Transformation Center services that will help ACMC to build this capacity.

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

*

Achievement Value

DSRIP Semi-Annual Reporting Form

Category 1: Expand 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
(insert milestone)

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

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

Achievement

[If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:](#) *

Results: ACMC has developed and approved plans to expand primary care capacity in Oakland by 15% by DY10. We successfully initiated and completed construction of an 8,500 square foot expansion at Oakland Eastmont Wellness Center that allowed expansion of adult medicine from 8 exam rooms to 16 exam rooms and provided space for 2 additional pediatric exam rooms. We hired additional primary care providers and supporting staff to provide care in the expanded space at Oakland Eastmont Wellness Center. The new pediatric space opened for operations in February, 2012.

We successfully completed a business plan and initiated construction to house a new same-day clinic with 11 additional exam rooms at the Highland Care Pavilion tower, which is currently under construction and is scheduled to open in Spring 2013.

ACMC is aiming to improve access to primary care through expansion of available space and clinicians as well as improved processes. ACMC currently has two primary care locations in Oakland: one at the historic Highland Campus, and the other at the Central-East Oakland location of the Eastmont Mall (Eastmont Wellness Center). Until planned new locations are built or acquired, our strategy is to maximize the use of existing sites to expand access.

A preliminary business plan has been developed for a yet-to-be-determined site in North Oakland for primary care expansion. We have contracted with a realtor to search for potential North Oakland properties; six potential sites have been reviewed but did not meet criteria. Review of additional properties is ongoing.

We have worked diligently to expand access by improving productivity. We have several initiatives underway aimed at improving clinic efficiency and throughput, including the new NextGen Electronic Health Record (EHR), patient visit re-design and Lean process improvement. Activities have included review and modification of provider schedules, streamlined registration, streamlined triage, increased support staff, and workflow optimization of providers and medical assistant staff.

In addition, starting in September 2011 we added primary care clinic hours on Saturdays at both our Eastmont and Highland Oakland-based clinics; this has added an average of 35-40 additional visits per Saturday per site.

Despite these additions to service, as of 6/30/12 we had not yet seen an increase in primary care visits. Our baseline for FY 10/11 is 118,354 primary care encounters in Oakland; in FY 11/12 we delivered 118,330 encounters. When we look at our visits per month at the two sites, there is an upward trend at Highland during FY 11/12, and a downward trend at Eastmont. This is partially attributable to the slow-down in productivity related to May 2012 EHR launch at Eastmont Wellness Center. In addition, the new adult medicine provider positions at Eastmont were not filled until May 2012, and at that time they were able to help counteract the reduced productivity due to the EHR implementation.

We anticipate that limitations on additional space expansion at existing sites, the tight market for primary care providers, and the lengthy provider and staff recruitment process will be barriers to achieving the goal of a 15% increase in encounters. We will be monitoring the data closely to see if the improvements we have put in place result in growth in visits.

At the system level, another challenge for primary care expansion is the simultaneous need to increase specialty care. ACMC is the major provider of specialty care to the safety-net population in Alameda County. Thus, even though the need for primary care access is clear, ACMC has a special responsibility to our partners in the community as well as our own patients to expand specialty care. With limited resources for expansion, these two priorities have to be balanced. ACMC is developing a three-year strategic expansion and sustainability plan that will address this balance; the upcoming plan modification will propose changes that reflect our decisions regarding these two essential priorities.

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

Achievement Value

DSRIP Semi-Annual Reporting Form

Category 1: Expand Primary Care Capacity

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.	
	<i>(insert milestone)</i>	
Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)		* <input style="width: 100%;" type="text"/>
Denominator (if absolute number, enter "1")		* <input style="width: 100%;" type="text"/>
Achievement		<input checked="" type="checkbox"/> Yes
		* <input style="width: 100%;" type="text" value="Yes"/>
<p>If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:</p>		
<p>Results: ACMC has successfully completed and approved a business plan to implement a 24/7 Nurse Advice Line for all ACMC primary care clinics.</p> <p>ACMC set the goal of establishing a Nurse Advice Line as a strategy to encourage appropriate use of resources, to provide patients with guidance to the right level of care at the right time, to support patients in managing their own care and to increase overall patient satisfaction.</p> <p>The Nurse Advice Line will be a contracted service; potential vendors were evaluated based on an analysis of provider accreditation, cost, triage protocol, interpretation capability, local presence, reporting/statistical analysis capability, time spent on calls, access to health libraries, multiple services offered, and scheduling capability. CareNet was selected as our vendor and discussion of contract terms, operating processes and reporting and communications criteria has been initiated.</p> <p>The CareNet Nurse Advice Line will be staffed by licensed State of California nurses. Services will include symptom assessment and telephone triage, urgent and non-urgent care advice, and a library of medical help topics patients can access. CareNet will provide daily morning reports of all calls received, including problem summaries and nurse recommendations. Designated clinic staff will be responsible for receiving and reviewing the daily reports and ensuring follow-up is completed.</p> <p>The implementation plan calls for a stepped roll-out of the program in order to enable us to test work-flows and make adjustments as we go. The program will start with pediatrics only, at the two smallest primary care sites, Newark and Winton Wellness Centers. It will then roll out to pediatrics at Eastmont and finally Highland. At approximately three months post-launch, adult medicine patients will be invited to use the line, again starting with the two smallest sites, and adding Eastmont and lastly Highland by the end of FY 12/13.</p> <p>In planning for the Nurse Advice Line, we gathered lessons learned from a pilot program using a Nurse Advisor in the Ambulatory Call Center that started in July 2011. From this experience we were able to estimate the potential demand (without marketing) and its potential impact on clinical acute care demand. Clinicians and staff were engaged to give input regarding the timeline, the rollout plan, and the communications that will be required from the vendor to ensure continuity and follow-up.</p> <p>Our greatest barrier regarding the launch of the Nurse Advice Line is concern about being able to meet potential increased demand with our limited primary care access. The new Highland Care Pavilion, currently under construction and scheduled to open in the spring of 2013, will house a same-day clinic with 11 additional exam rooms. This will help to meet the needs of adult patients who call the Nurse Advice Line and are in need of treatment.</p> <p>In the meantime, to manage this problem we plan to initially limit the Nurse Advice Line service to our pediatric patients. Due to expansions in DY7, we have more capacity for additional appointments in pediatrics than in adult medicine, so we can best meet new demand in these clinics.</p> <p>With regard to sustainability, we will monitor impact on visits and costs on a monthly basis. In FY 14/15 we will conduct an assessment to determine the impact on utilization, patient experience and other relevant factors; and analyze the business case for continuing maintenance of the Nurse Advice Line.</p>		
DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone		* <input style="width: 100%;" type="text" value="yes"/>
<i>Achievement Value</i>		<input style="width: 100%; border: 1px solid blue;" type="text" value="1.00"/>

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
 DPH SYSTEM: Alameda County Medical Center
 REPORTING YEAR: DY 7
 DATE OF SUBMISSION: 3/22/2013

REPORTING ON THIS PROJECT: *

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:	* <input style="border: 1px solid black; width: 100px;" type="text" value="\$ 4,899,750.00"/>
Incentive Funding Already Received in DY:	* <input style="border: 1px solid black; width: 100px;" type="text" value="\$ 4,287,281.25"/>
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.
	<i>(insert milestone)</i>
Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	* <input style="border: 1px solid black; width: 80px;" type="text" value="163.00"/>
Denominator (if absolute number, enter "1")	* <input style="border: 1px solid black; width: 80px;" type="text" value="198.00"/>
Achievement	<input style="border: 1px solid black; width: 80px; background-color: black; color: white;" type="text" value="0.82"/>
If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:	* <input style="border: 1px solid black; width: 100px;" type="text"/>
<div style="border: 1px solid black; padding: 5px;"> <p>Numerator = # Providers, Residents, Staff Trained Denominator** = # of relevant providers, residents, and staff deemed to need training as part of the panel management program</p> <p>**Our denominator for total providers, residents, and staff has changed slightly since our midyear report. This is due to 1) The number of providers and staff deemed to need training as part of the panel management program has increased to 153, of whom 125 have been trained; and 2) In counting the denominator for the resident panel management training program, we incorrectly included preliminary residents who do not complete their residency training here and do not participate in continuity clinics. During DY7, the number of relevant R1, 2, and 3 residents was 45, of whom 38 were trained in panel management.</p> <p>Results: ACMC trained 82% 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. Of 106 non-provider staff from 4 primary care clinics (Eastmont, Newark, Winton, and Highland), 90 have been trained; out of 47 providers, 35 have been trained.</p> <p>ACMC has been actively developing and spreading the panel management program in our four adult primary care clinics throughout this year, as described in the Registry Functionality Milestone report. Foundational to this implementation has been the training of clinicians and staff in principles and practice of panel management.</p> <p>There are two components to our panel management training program. The first is aimed at the regular clinical and support staff at each primary care site. In addition, as a teaching hospital we have also incorporated a special panel management training program for our internal medicine residents. This is funded in part by a Bureau of Health Professions Primary Care Training and Enhancement Grant, and is described below.</p> <p>We successfully met the DSRIP milestone by targeting clinic team meetings and provider meetings. Topics included the chronic care model, principles of panel management, use of the ACMC disease registry ("i2i tracks"), and the specifics of the ACMC panel management program. The training materials were reviewed and revised periodically to represent programmatic (protocol) changes.</p> </div>	

DSRIP Semi-Annual Reporting Form

Category 1: Implement and Utilize Disease Management Registry Functionality

Provider and staff trainings were delivered in a variety of ways. Most medical providers were trained in one of their monthly provider meetings. Most clinic staff was also trained in one of their monthly staff meetings. Other staff members were trained in a site-specific, multidisciplinary quality improvement team meeting, and some were trained one-on-one. A PowerPoint presentation was developed that highlighted the purpose and definition of panel management and how it was currently being implemented at ACMC.

The panel management (PM) team, which includes panel management coordinators, a clinical data coordinator and the health education manager, deliver the training. Participants were encouraged to offer feedback to the PM team during trainings. Providers and other clinic staff often make suggestions that the PM team incorporates into program operations. For example, pediatric providers recently expressed an interest in developing a panel management program for the pediatric population, and we are in the process of developing that project now.

Twenty one ACMC staff, mostly providers, participated in a half-day interactive training on Chronic Disease Care: Using Data and Panel Management in January 2011. This interactive workshop covered principles of panel management such as using i2i Tracks; selection criteria and standing orders; how to analyze registry data; and the Alameda County Panel Management Standard of Care (which was developed as part of our Coverage Initiative collaboration). Attendees also heard from a panel of peers with experience using panel management in their practices. This workshop, which was developed by our community safety-net quality committee, is sponsored by Alameda County Health Care Services Agency and is periodically repeated and open to all safety-net healthcare providers.

Challenges have included finding time on already-full meeting agendas, and careful tracking and follow-up with staff members who missed the team meetings where training was held. Perseverance and good working relationships between the PM program team and clinic leadership have been instrumental in ensuring that training time is protected for staff.

A lesson learned through this process is that, in our busy environment, which is undergoing simultaneous and widespread changes, a one-size-fits-all strategy is not effective. We were able to train most of the staff at team meetings; however some staff members were trained one-on-one when the opportunity arose. Flexibility and persistence were essential.

Another lesson learned through our training and implementation of the PM program was the understanding that adult learning and behavior change require more than one exposure. Therefore, many of the staff trained heard the PM presentation on multiple occasions, both formally and informally. However, the repetition of the information in the day-to-day operations was crucial for cementing the knowledge of the program. Additionally, the panel management coordinators (PMCs) and the PM program director both regularly checked in with staff and made it easy for the staff to ask questions and get answers in the moments they arose. Reiterating the goals and implementation strategies at every opportunity have also been keys to successful implementation.

It should be clear from the description above that the program has been very interactive and that stakeholders have been very involved. In addition to the bi-directional communication during trainings and staff meeting, we have a multidisciplinary steering committee that reviewed presentation materials before they were used. This committee includes an adult medicine physician, medical director, panel management coordinator, clinical data coordinator, and the health education manager. This engagement and two-way exchange of information is what has made our success possible.

Regular training will be the key to sustainability of the panel management program. Now that most of the staff has received in-depth training on concepts related to panel management, future trainings will be shorter. Our DY8 milestone specifies that we will integrate refresher training into annual training plans for all primary care clinic clinical staff and achieve a minimum of 75% completion of training by clinical staff. Formal training, re-training and refresher training will occur at monthly staff and provider meetings on an annual basis, or more frequently if needed. Initial orientation and training for new staff will occur during clinic where "in-reach" occurs (in-reach part of the panel management program in which care gaps are identified for patients who are coming in for an appointment and if appropriate, are addressed by the medical provider.)

The fact that the panel management coordinators are well-integrated into clinic operations and are actively engaging the providers and staff in team-based panel management also contributes to sustainability of the program.

DSRIP Semi-Annual Reporting Form

Category 1: Implement and Utilize Disease Management Registry Functionality

Meanwhile, on the residency training part of panel management, the internal medicine faculty has developed an extensive panel management practicum using the Chronic Care Model (CCM) components for internal medicine residents. The practicum consists of: 1) a didactic session during which a bio-psychosocial approach is presented and applied to four major areas of chronic disease care; diabetes, cardiovascular disease, chronic pain and health care maintenance; 2) use of an electronic population management tool (i2iTracks) 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 complete the practicum during 11 half-day sessions per year, during which four different residents are supervised by one faculty member.

The success of the residency panel management training program is evaluated using a survey distributed online through the vendor Survey Monkey. The survey includes 9 questions related to the reception of the course as well as the effect the course had on the resident's clinical experiences. In addition, there is the opportunity to make general comments. Of the residents that had filled out the survey as of May 2012, 28/29 responded saying that the introductory session gave them an adequate understanding of the Chronic Care Model and the purpose of panel management. 24/29 residents said that the panel management activities enabled them to plan and implement strategies to help their patients bring their chronic diseases under control, and that the resident's quality of experience during K-6 clinics had changed since participating in PM. Overall, 27/29 residents felt that the panel management sessions were a valuable use of time.

A few comments from the residents about the panel management residency training program:

"Panel management ... gave us time to think about the needs of our patients and tend to them without time constraint"

"...overall P.M. has been a really useful tool for an otherwise hectic and chaotic clinic experience."

"It would be great if we have protected time every week/2 weeks to look ahead our patients' issues and have a plan in advance"

"...Also made me increasingly aware of chronic health issues and the goals of care associated with these."

The director of the residency panel management program is currently writing an article documenting the results of the program that will be submitted to academic journals.

Some of the challenges that the resident panel management program has faced include inaccuracy of patient data and panel assignments. The panel reports that are produced by i2i tracks use diagnosis data from the billing codes, however, this is often not an accurate representation of all elements of a patient's diagnosis that are useful for panel management. In addition, when patients come into clinic the registration staff often assigns them to an incorrect resident when they do not belong on that resident's panel. These mistakes in assignments create inaccurate panels and create difficulties for both patients and medical staff.

With the PMCs now fully-staffed and much of the program setup accomplished, we hope to make improvements in these issues in 2012. The implementation of the EHR, which is in use at the three free-standing sites but is not yet rolled out in the Highland ambulatory care program, should also help resolve these issues.

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

Achievement Value

*

DSRIP Semi-Annual Reporting Form

Category 1: Implement and Utilize Disease Management Registry Functionality

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

If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:

*

As of December, 2012, ACMC has completed our DY7 milestone related to implementation and utilization of a Disease Management Registry.

75% achievement of this milestone was claimed in the 2nd semi-annual DY7 report submitted in September 2012 because 3 out of 10 clinicians participating in panel management had not yet had their panels reviewed for accuracy of diabetes diagnosis. The process of reviewing patient records and validating the diagnosis is time-consuming and we were not able to finish before the end of DY7. The work for completing this milestone continued through the beginning of DY8 and we were able to review all clinicians participating in panel management. The process was the same as described in the original narrative (see below). The current results for this milestone are as follows:

Results: We have three measures for success for this milestone:

1. Hiring: Four out of four panel management coordinator positions were filled.
2. Empanelment: Ten out of ten clinicians participating in panel management had their panels reviewed and corrected for accurate patient assignment according to protocol.
3. Accuracy of diabetes diagnosis: Ten out of ten clinicians participating in panel management had their panel reviewed for accuracy of diabetes diagnosis.

Results: We have three measures for success for this milestone:

1. Hiring: Four out of four panel management coordinator positions were filled.
2. Empanelment: Ten out of ten clinicians participating in panel management had their panels reviewed and corrected for accurate patient assignment according to protocol.
3. Accuracy of diabetes diagnosis: Seven out of ten clinicians participating in panel management had their panel reviewed for accuracy of diabetes diagnosis.

The reason for partial achievement is simply that the process of reviewing patient records and validating the diagnosis is time-consuming. We anticipate this will be 100% complete by December 2012, and we will request the remainder of the milestone incentive payment in our next report.

In DY 7, a panel management program was implemented with adult medicine providers at all four ACMC primary care sites. A multidisciplinary steering committee which includes an adult medicine physician, medical director, panel management coordinator, clinical data coordinator, and the health education manager participated in developing the protocols and guidelines for the panel management program. Products included:

- A panel management protocol which includes diabetes, hypertension, Pap tests, mammograms, CRC screening, pneumococcal and influenza vaccine; two providers at each outpatient clinic piloted the protocol
- Telephone scripts, health education materials and process flow diagrams
- A chart audit to collect baseline data
- Program goals and program brochure
- A process for "scrubbing" provider panels

The panel management protocol spells out specifically what the panel management coordinators will do based on a variety of selection criteria. To briefly summarize, the panel management coordinators print a patient visit summary from the health registry for each patient presenting in the clinic for a visit. The panel management coordinator highlights any care gaps on the patient visit summary related to diabetes, hypertension, or preventive health, and the provider acts upon the recommendations as appropriate. The providers report that these cues are helpful reminders and often result in providers and patients working together to close the identified care gaps.

Clinicians' engagement has been a key to success. Initially, a few were skeptical and were concerned that panel management would increase their workload. However once the program was launched, the panel management team received numerous requests to participate in the in-reach process (in-reach is part of the panel management program in which care gaps are identified for patients who are coming in for an appointment and if appropriate, addressed by the medical provider.)

DSRIP Semi-Annual Reporting Form

Category 1: Implement and Utilize Disease Management Registry Functionality

Clinicians' ideas and feedback are incorporated into program implementation. Additionally, these providers serve as program ambassadors for other providers not yet participating in the program.

The team experienced a number of barriers while attempting to reach the milestone of "cleaned and validated" provider reports. One significant challenge was ACMC's multiple current computer systems and an inconsistent and frequently inaccurate identification of the primary care provider in the system. This does not yet have an automated solution, however we are hoping that the new enterprise-wide practice management system scheduled to "go-live" in 2013 will improve this greatly.

The implementation of the panel management program has been an ongoing process of testing and improving interventions using quality improvement processes. For instance, the team has used both qualitative and quantitative data to modify the utilization of the patient visit summary as a communication tool. To illustrate, the patient visit summary form asks providers to give feedback about care gap closure (e.g., completion of a foot exam). Initially, the form was used inconsistently. Investigation revealed that we needed to standardize the symbols providers used to communicate back to the panel management coordinators. A legend was created to clear up communication.

There have been many lessons learned in the development and implementation of the panel management program. Feedback has led to modification of the patient visit summary, addition of a preventive health indicator, and delaying the outreach part of the protocol, due to visit capacity limitations. The team is currently beginning to experiment with implementing the outreach component of panel management by moving patients with diabetes who are lost to care into group medical visits.

The panel management / registry program has many system-level implications. The panel management program is working closely with the care transitions and medical home projects to facilitate movement of patients from one level of care to another. We are all working with the Electronic Health Record (EHR) implementation team to plan for the EHR design that will support the new processes we are implementing as part of creating medical homes. For example, a field to identify the primary care provider as well as the medical home, and how the EHR might be able to "push" information to different parts of the system to aid with care transition coordination.

Training related to panel management is addressed in its own milestone.

We have had turnover in panel management coordinators, so we have developed strategies to sustain the program. We have "buddied up" panel management coordinators so that continuity is not lost if someone moves on. In addition, we provide professional development by engaging them in clinical quality-improvement projects.

Many of the activities we have engaged in this year in launching the panel management program are related to data clean-up, the mechanics of getting the patients properly empaneled and producing reports. We have found it important, in the midst of this sometimes-tedious groundwork, to keep in mind why we are doing this work: to help patients and providers to form a healthcare team that supports the patient in maintaining the best health through self-management. Here is one patient story that illustrates how the system is working at ACMC and why it is important:

Ms. Y had poorly controlled diabetes, high blood pressure, and depression, and was struggling to keep up with her medications. Through use of the registry system, the care team identified her as someone who might benefit from health coaching and group visits. A health coach provided one-on-one teaching about her disease and how she could manage it herself; she attended group learning sessions where she also got peer support. With this help, Ms. Y has her diabetes and blood pressure under control (she dropped her HbA1C by 2 full points and her systolic BP by 30 mmHg). She also lost 20 lbs., which was crucial to her successes and enhanced her self-esteem.

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

REPORTING ON THIS PROJECT: *

Category 1: Expand Specialty Care Capacity

Below is the data reported for the DPH system.

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

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

Expand Specialty Care Capacity	
DY Total Computable Incentive Amount:	* <input style="border: 1px solid black; width: 100px;" type="text" value="\$ 4,899,750.00"/>
Incentive Funding Already Received in DY:	* <input style="border: 1px solid black; width: 100px;" type="text" value="\$ 1,837,406.25"/>
Process Milestone:	Increase optometry encounters by 20% compared to baseline (ACMC FY 2010). Metric:
	<u>Encounter data for baseline and demonstration year.</u>
	<i>(insert milestone)</i>
Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	* <input style="border: 1px solid black; width: 80px;" type="text" value="6,590.00"/>
Denominator (if absolute number, enter "1")	* <input style="border: 1px solid black; width: 80px;" type="text" value="2,899.00"/>
Achievement	<input style="border: 1px solid black; width: 80px;" type="text" value="2.27"/>
If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:	* <input style="border: 1px solid black; width: 100px;" type="text"/>
<div style="border: 1px solid black; padding: 5px;"> <p>Numerator = # Encounters from 7/1/2011-6/30/2012 = 6,590 Denominator = Baseline Encounters (FY 09/10) = 2,899</p> <p>Results: ACMC exceeded its target of increasing optometry encounters by 20% as compared to our 2010 baseline. In FY2011, we more than doubled our encounters, providing 6,590 optometry encounters, an increase of 127% over baseline.</p> <p>Expansion in safety-net ambulatory care services, in both specialty and primary care, is a critical need in Alameda County. Throughout DY7 ACMC has been planning and implementing expansions in specialty care services. Simultaneously, we have been developing an over-arching strategic plan that will encompass and build on the expansions that are reported here.</p> <p>Because the need is so great, we have planned to exceed some of our DSRIP targets, and we will be considering this as we propose our DSRIP plan modifications in the coming months.</p> <p>Our experiences in expanding these clinics are informing our planning for the larger expansion, as we better understand the challenges in the environment and in our organization.</p> <p>The main driver for the increase in optometry services was the leveraging of ACMC's partnership with the University of California, Berkeley School of Optometry. We also added an optometry room at Eastmont Wellness Center. The School of Optometry provides the equipment and the optometry students do the intake and discharge activities. This is a real "win-win" situation—ACMC patients get a greatly-needed service, and the students get a wonderful training opportunity.</p> <p>Optometry services were expanded at three clinic sites: Eastmont, Highland and Newark. Eastmont Wellness Center added three days of service, for a new total of six days of optometry service, including glaucoma and diabetic screening. As a result, the wait time for appointments at Eastmont dropped from over six months to approximately three months. In addition, six additional four-hour sessions for diabetic retinopathy screening were added at Eastmont, bringing the number from four to ten half-day sessions per week.</p> </div>	

DSRIP Semi-Annual Reporting Form

Category 1: Expand Specialty Care Capacity

The Highland optometry service started new Saturday clinics on January 7, 2012. The clinic is staffed with one supervising optometrist, one resident, and two or three optometric interns from the School of Optometry. This has added about 30 new appointment slots per week at the Highland Campus. In the first six months of operation (January-June 2012), the Highland optometry clinic provided 388 visits.

Retinal screening started at the renovated Newark Wellness Center in October 2011 and provided an additional 443 optometry visits in FY 11/12.

Patients are referred to ophthalmology when appropriate; patients with on-going problems are given return appointments, and many patients are seen for annual exams.

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

*

Achievement Value

Category 1: 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.

(insert milestone)

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

*

Denominator (if absolute number, enter "1")

*

Achievement

[If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:](#)

*

Results: ACMC has developed business plans to increase cardiology, dermatology, and orthopedic encounters by at least 15% each compared to baseline (ACMC FY 2011), by DY10. Many planned changes were implemented in DY7, as described below.

Expansion in safety-net ambulatory care services, in both specialty and primary care, is a critical need in Alameda County. Throughout DY7 ACMC has been planning and implementing expansions in specialty care services. Simultaneously, we have been developing an over-arching strategic plan that will encompass and build on the expansions that are reported here.

Because the need is so great, we have planned to exceed some of our DSRIP targets, and we will be considering this as we propose our DSRIP plan modifications in the coming months. Our experiences in expanding these clinics are informing our planning for the larger expansion, as we better understand the challenges in the environment and in our organization.

ACMC has adopted an overall goal of expanding access to six key specialties including orthopedics, cardiology and dermatology by FY 2015 to meet the key access criteria of reducing wait time to 30 days or less. ACMC is designing its specialty care expansion program to address other factors that impede access, including eliminating the backlog of patients awaiting scheduling, achieving a positive ratio of available new appointment slots compared to referrals, and increasing our provider staff to within 70% of national physician-to-patient ratios.

Over the period August-October 2011 ACMC conducted a gap analysis of safety-net specialty care capacity in the county. In addition to analysis of utilization and referral data, ACMC and community clinics Primary Care Providers (PCPs) were surveyed in October 2011. PCPs were asked to rank the top five specialties that, in their opinion, ACMC should prioritize for development over the next two years. We received a response from 41 PCPs identifying their top priorities for expansion. Orthopedics was the top-priority specialty cited for importance to expand; dermatology was third, and cardiology ranked fifth.

Orthopedics: Through a combination of reorganization, added space and added personnel, ACMC's orthopedics program increased visits by 22% for FY 11/12 compared to FY 10/11.

In November 2011, a biweekly orthopedic clinic session was started at the Newark Wellness Center (106 encounters). Newark Wellness Center underwent a major remodel and expansion in 2011, and this is the first specialty clinic to be established after the expansion. Newark was an attractive site for out-stationing orthopedics because it has a radiology room, a basic requirement for orthopedics, and because it serves the southern Alameda County area which is distant from the Highland Campus.

In December 2011, a weekly orthopedics Hand Minor Surgery Clinic was started at Highland Hospital. A hand and shoulder specialist holds an additional session once monthly, performing procedures such as carpal tunnel release, trigger finger release, removal of finger masses, etc. Because these procedures are performed using local anesthesia, this expansion freed up operating room time for more complicated orthopedic issues.

In March 2012, orthopedics clinic added a new weekly session at Highland Hospital, which increased the weekly orthopedics sessions from four to five.

Finally, orthopedics clinic was one of the first areas of ACMC to be selected as one of our Lean program projects (see report on our Performance Improvement milestone). The first phase of this process, known as 5S, has been completed and has resulted in reconfiguring the clinic workspace to be more efficient and better organized. A Kaizen on discharge processes took place at the end of June, and 11 people participated. Upcoming portions of the Lean engagement will redesign the scheduling system and improve workflow processes during clinic visits.

These improvements led to a 31% decrease in the orthopedics backlog, and the ratio of new referrals to available new appointments was reduced from 1.28:1 in September 2011 to 1.16:1 in May 2012.

Category 1: Expand Specialty Care Capacity

Cardiology: APMC's cardiology clinic has been able to increase visits by 22.4% for FY 11/12 compared to FY 10/11. The cardiology clinic moved to a renovated space on Highland Campus on February 27, 2012, which provided eight exam rooms, a patient waiting room, nurses' station and clinician workspace. A new cardiologist joined APMC in December 2012; she devotes .2 FTE to staffing the cardiology clinic in addition to her duties in the echocardiogram lab.

With the move to the renovated clinic space, cardiology added a third half-day per week of clinic time. There are now two cardiologists at each of the three clinic sessions, one working with residents and the other seeing patients on their own in a faculty practice. New clinic templates were created to reflect these changes. In addition, a new staff model for cardiology was implemented: one medical assistant (MA) is assigned to work with each provider, allowing patients to move more efficiently through the clinic and improving the patient experience.

These improvements led to a 52% decrease in the cardiology backlog, and the ratio of new referrals to available new appointments was reduced from 1.62:1 in September 2011 to 1.38:1 in May 2012.

Dermatology: FY 11/12 visits went up by 6.4% from 1,087 to 1,156 compared to FY 10/11. As of June 2012, dermatology provider capacity has not increased; our expansion work in dermatology this year has been preparing for implementation of teledermatology. APMC is partnering with University of California at San Francisco (UCSF) to bring teledermatology services to APMC. Through this service, PCPs will write up the patient's skin condition and nursing staff will digitally photograph the affected area(s); these materials will subsequently be securely transmitted to UCSF's dermatologists, who will review the images and send an assessment back to the referring provider.

As of June 30, 2012, we have negotiated the contract with UCSF, evaluated multiple software vendors and selected one, Medweb, which has been installed on computers at Eastmont Wellness Center, the first site for implementation. Superusers were scheduled to be trained in the Medweb system, and prepared to train other participating providers.

Further expansions planned for FY12/13 include recruitment of additional providers in cardiology and orthopedics, expansion of clinic hours, continuation of the Lean process in orthopedics, and implementation of the teledermatology program. After a five month recruiting process in 2012, a new cardiology physician's assistant was hired to start in August and will augment clinic services provided by our staff cardiologists and residents.

The greatest challenge to successfully implementing our plans for specialty care expansion is the recruitment of specialty care providers, be they physicians or mid-level providers. Part of APMC's strategy for expanding access is to use mid-level providers (MLPs). Our early recruitment efforts have taught us that MLPs with specialty experience are few in number and in very high demand. One strategy when we are unable to find appropriate MLP specialists is to seek to hire experienced MLPs and train them more deeply in the specialty.

Another big challenge facing APMC is lack of physical space for specialty care expansion. The Highland campus has a dedicated specialty clinic floor, and there was an expansion of specialty clinic space in an additional renovated Highland location in February 2012. Eight exam rooms were added and these spaces are already full to capacity or beyond (note these 8 rooms will eventually be gone, as they are in the old acute care building which will be torn down in approximately five years). Construction of a new dedicated specialty clinic area with 16 exam rooms at Eastmont Wellness Center will be completed in FY 12/13, enabling a significant expansion of clinic sessions. APMC is also looking for suitable locations for additional clinics to allow for needed expansion of both primary care and specialty care services.

Another challenge is that growing specialty care services will increase demand for ancillary services and especially for operating room time. If these related services don't expand, then a new backlog of patients awaiting the needed service is likely to be created. Planning for overall, coordinated expansion is part of the larger strategic plan mentioned above.

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

REPORTING ON THIS PROJECT: *

Category 1: Enhance Performance Improvement and Reporting Capacity

Below is the data reported for the DPH system.

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

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

Enhance Performance Improvement and Reporting Capacity	
DY Total Computable Incentive Amount:	* <input type="text" value="\$ 4,899,750.00"/>
Incentive Funding Already Received in DY:	* <input type="text" value="\$ 3,266,500.00"/>
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.
	<i>(insert milestone)</i>
Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	* <input type="text"/>
Denominator (if absolute number, enter "1")	* <input type="text"/>
Achievement	<input type="text" value="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:	* <input type="text" value="Yes"/>
<p>Results: ACMC has established the System Transformation Center (STC) in order to assist in achieving and sustaining the system transformations needed to enable ACMC to succeed under health reform by improving access and coordination of care across our system. The STC is responsible for ensuring that the DSRIP projects and other system transformation projects occurring in this very dynamic period at ACMC are coordinated, synergistic, well documented, and spread throughout the organization. By aligning improvement efforts and improving communication across the organization, we will increase efficiency, reduce redundancy and turn the frustration of multiple uncoordinated change efforts into the satisfaction of successful progress toward objectives.</p> <p>Accomplishments in DY7</p> <ul style="list-style-type: none"> - Establishment of a DSRIP Oversight Committee comprising executive and medical staff leadership in June 2011. This group has met monthly to review progress on milestones and approve funding for projects. The oversight committee has relied on the clear vision established by the STC Plan created in DY6 to guide spending decisions, ensuring the DSRIP dollars are used for system change and not folded into operations. - Staffing for the STC: The DSRIP Administrator began as a consultant in the fall of 2011, and was hired in January 2012. The administrator has supported implementation and achievement of DSRIP milestones, developed an accountability structure for leadership of all of the projects, communicated to staff about DSRIP and the system transformation center vision, and facilitated leverage and linkage of DSRIP milestones to larger organizational projects (e.g., Care Transitions). The Director of Organizational Learning and Effectiveness was hired in April 2011. The STC Executive Director was hired in June 2012. - Development and submission of a four-year work plan, described below. <p>A significant challenge we faced in the establishment of the STC was the time it took to find the right person for the role of Executive Director. The fact that the leadership position was still vacant as we entered the second half of the year meant we had to decide whether to delay the development of the plan or to go forward to develop a plan that the new Executive Director would be responsible for implementing.</p>	

DSRIP Semi-Annual Reporting Form

Category 1: Enhance Performance Improvement and Reporting Capacity

Knowing how critical the STC and its services would be to the transformation that ACMC aspires to achieve, we decided to move forward with development of the four-year work plan. A team of consultants was engaged, and worked closely with the CMO and the DSRIP administrator throughout the spring of 2012. They designed a planning methodology and developed the four-year work plan. The planners were aware of the need to create a plan that could be adapted to match the individual leadership style and approach of the incoming Executive Director. They aimed to make the plan specific enough to be applicable and relevant, but not so detailed that it would be overly constraining.

The four-year work plan was submitted to the CEO, the new Executive Director and the DSRIP Oversight Committee in June 2012. To create the four-year STC work plan, the consulting team designed a research methodology which utilized four primary sources of information and data. These sources included: 1) Review of relevant literature; 2) Environmental scan of best practices in the field and available change planning documents within ACMC; 3) External research interviews with nationally recognized scholar practitioners in the field of system transformation; and 4) Internal interviews with key change leaders within ACMC, especially those who would be collaborating with the STC on an ongoing basis. These change leaders included both administrative and medical leadership.

Our research methodology resulted in a preliminary synthesis of key findings and grouping these findings into a primary goal statement and five major objectives for the STC. A "Draft System Transformation Center Work Plan" was created, which included the overall goal statement, five objectives, and specific strategies and activities by year. This draft work plan was subsequently reviewed and vetted by interviewees.

In the final System Transformation Center work plan, the five STC objectives are to:

1. Assist in aligning ACMC's planning and prioritizing processes.
 2. Make smart changes easier and better planned.
 3. Provide direct support for change projects.
 4. Bring the nation's best thinking on transformation to guide ACMC's changes.
 5. Create an internal communication network to engage and inform ACMC staff and physicians in the transformation.
- Each objective has associated metrics and activities. Appendices were developed summarizing the interviews, interview protocols, etc.

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

*

Achievement Value

DSRIP Semi-Annual Reporting Form

Category 1: Enhance Performance Improvement and Reporting Capacity

Process Milestone:

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 provide an in-depth description of progress towards milestone achievement as stated in the instructions:](#)

* Yes

ACMC staff has participated in several learning collaboratives this year, including:

1. ARC

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 December 2013.

ACMC formed a Reducing Readmissions Harm Reduction Team (HRT) in the spring of 2010. The members of the team include a wide range of stakeholders from various disciplines and departments: physicians, nurses, administrators and others; representing ambulatory care, the inpatient service, patient registration, the quality department, etc.

In late 2010, the HRT joined ARC and throughout 2011, we participated in quarterly learning sessions and monthly calls to share information and best practices. We applied for and were awarded an ARC Planning Grant of \$25,000 in February 2011, funded by the Gordon and Betty Moore Foundation. Guided by the ARC process and with the assistance of our ARC consultant, the HRT first went through steps to understand the problem. The team conducted chart reviews, administered key informant questionnaires from staff and patients and analyzed ACMC data on readmissions. We also participated in learning sessions and reviewed literature. The HRT decided to adopt the Project RED model for implementation at ACMC's acute care hospital, Highland Hospital.

In October 2011, the HRT completed and submitted its ARC reducing readmissions plan. The plan integrates many of the DSRIP projects. As described in the narrative for our Care Transitions milestone, the plan that was developed as part of the ARC collaborative was turned into a grant proposal to the Gordon and Betty Moore Foundation, and was funded in June.

In preparation for the grant, we were invited to participate in a Project RED training sponsored by Marin General and presented by Brian Jacks in February. We have also continued to participate in the quarterly ARC learning sessions. At the June session, our team presented a Resident Toolkit to the collaborative. This is a toolkit developed by the hospitalists with the HRT, to teach residents best practices for avoiding preventable readmissions, including teach-back concepts, the characteristics of a good discharge summary and a checklist, assessing for discharge readiness, referrals, etc. This will be incorporated into residency training starting this academic year.

ACMC is also participating in the NAPH Safety Network Collaborative for reducing readmissions. As part of this collaborative, the team will develop a 90-day action plan.

2. PExT

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.

In the second half of the year, ACMC successfully completed the 9-month collaborative program, meeting monthly milestones and action items by creating the project charter and plan and getting approval by key stakeholders. Our team was an active participant in all coaching sessions, webinars, networking opportunities and live trainings. Participants in the initiative included the Chief Nursing Executive as the executive champion, in addition to the Safety Coordinator, Patient Affairs Officer, Director of Respiratory Services, Assistant Director of Nursing, Medical Director of Patient Experience and Equity, and Organization Development staff.

In developing the PExT plan, the team collected data through focus group interviews and focus group summaries and analyzed the data at a PExT Experience Design Workshop. The design session was led by ACMC's Patient Experience Quality Analyst and attended by several nurses and one patient representative. The session focused on explaining and finding solutions for 5 gaps in patient experience: 1) providing patients with information about their care, 2) communication between nurses and other providers, 3) customer service skills, 4) communication between departments, and 5) patient wait times. The responses and data gathered from this gap exercise were grouped together and consolidated into a list of potential solutions. From this list, the PExT team chose three solutions to prioritize based on urgency of need within the sphere of the Nursing Department. The three solutions

DSRIP Semi-Annual Reporting Form

Category 1: Enhance Performance Improvement and Reporting Capacity

chosen to focus on were 1) developing a patient orientation to the unit upon admission; 2) finding creative ways to educate patients in house; 3) using technology (electronic order tracking, translation apps, call light systems, nurse telephones, etc.). ACMC sent several representatives to present on the Experience Design Workshop results at the June 5th PExT Innovation Showcase sponsored by SNI.

The team plans to continue with the PExT collaborative through January 2013, making use of the coaching and learning opportunities that are offered through the program, and plans to host a PExT design and mapping session for all collaborative participants.

3. ELNEC

The End-of-Life Nursing Education Consortium (ELNEC) Public Hospital Project is a two-year collaborative supporting palliative care nursing that 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. In the first part of the year, 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.

In the second part of the year, the team delivered trainings as detailed below:

- the palliative care coordinator, an intensive care RN, nursing education clinical instructor, and members of the nursing staff taught two full-day training courses to nurses, nurse-assistants, and social workers on February 8th and 11th at Highland Campus (37 participants). This course included an introduction to Palliative Care and Pain Management, and presentations on symptom management, care for the imminently dying, and grief, loss and bereavement. Activities included presentations, group exercises, videos and role plays
- 'Care for the Imminently Dying' was taught at Fairmont campus (20 participants)
- 'Palliative Care and Pain Management' was taught at Fairmont campus (20 participants)
- Initiated Hospice Education Network (HEN) page on ACMC intranet
- Participated in monthly calls with other public hospitals as part of the ELNEC learning collaborative

The ELNEC team has had many great opportunities in the planning process for this work, including participating in educational sessions both in person and through remote training, support to develop a plan to increase skills and competencies, mentoring calls and site visits.

Our learning collaborative aim is to have palliative care become an essential part of nursing care at ACMC. In order to increase exposure on palliative care topics to staff nurses, charge nurses have reviewed cases with their staff and helped with referrals. Bulletin boards at Highland Hospital and Fairmont (ACMC's skilled nursing and rehabilitation campus) are regularly updated with information on the criteria for palliative care, clarification of Palliative Care vs. Hospice case, and updates on education. Data collected by the Palliative Care Team show that the number of referrals for palliative care has increased by 30%.

Additional accomplishments of the Palliative Care Team include:

- Completing pages on Palliative Care and the Physicians Orders for Life Sustaining Treatment (POLST) form for the hospital admissions binder
- Meeting with Hospice partners and collaborating on the development of a discharge checklist to help streamline our discharges from the hospital to "home with hospice" or "nursing home with hospice" so there are no lapses in crucial medicines provided to those patients
- Developing a new electronic code status and life-sustaining treatment orders that mirrors the POLST form

A challenge that we are facing is related to the new EHR computer system, which is coming to the medical center in 2013. During the implementation phase the EHR planners are not making changes to the system so the Palliative Care team is unable to meet its objective of placing Palliative Criteria on the nursing assessment page until "phase 2" of the new computer system.

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

*

Achievement Value

DSRIP Semi-Annual Reporting Form

Category 1: Enhance Performance Improvement and Reporting Capacity

Process Milestone: 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 provide an in-depth description of progress towards milestone achievement as stated in the instructions:](#)

*

Results: ACMC completed and signed a services contract to implement a three-year Lean-Six-Sigma training initiative at ACMC. The program was launched and fully operational by the end of DY7.

We have established an infrastructure for the Lean program that includes a Kaizen Project Office (KPO), a dedicated Director of the KPO, an event coordinator, and a post-event follow-up coordinator. The Lean program is under the direction of the Executive Director of the System Transformation Center (STC) and the Chief Operations Officer is the Lean Executive Champion.

Lean implementation includes identification of key stakeholders, individual outreach, education around the Lean project, employment of Lean tools, and communication around project organization and follow up. A plan and detailed schedule are in place to guide Lean implementation throughout the hospital system. As of June 30, 2012, Value Stream Mapping (VSM) was underway according to schedule for inpatient hospital flow, psychiatric emergency services, and adult orthopedic clinic. By the end of 2012, the Outpatient Pharmacy and Emergency Department will also be in process. From January to June, seventeen separate events, many of them lasting 4-5 days, have been organized and delivered by the KPO.

Wave One of basic training in Lean / Six Sigma was targeted to the executive level. Seven days of training were held from August 2011 through June 2012, covering topics such as TPS Fundamentals, VSM, 5S Visual Management, and other Lean concepts. Wave Two training, covering similar topics, is targeted to Directors, and began in June 2012. Supervisors and staff are scheduled to be trained in subsequent waves. There were 24 participants in Wave One, and 17 are participating in Wave Two. After completion of the full training, participants will be certified Lean Workshop Leaders.

The first VSM started in January 2012 and focused on Inpatient Flow. This was a week-long event attended by 17 people, including the chief Medical Officer, Chief Nurse Executive, and Vice President of Quality, physicians from the Emergency Department and inpatient services, a representative from the Patient Advisory Council, the director of Medical Social Services, nurses, and others. The subsequent Kaizen events focused on (1) Start discharge planning at admission; (2) Discharge decision to patient released; (3) Discharge medications; (4) Financial screening; and (5) Discharge planning coordination. In all 61 people participated in the inpatient flow Lean events.

The second VSM that was launched this year was in the Adult Orthopedic Clinic. The VSM was held February – March 2012, and was attended by eleven staff, including the Director of Perioperative Services, the Director of Patient Services, nurses and medical assistants, among others. The Kaizen events that were planned focused on 5S, the clinic discharge process, the provider-MA workflow, and the scheduling and referral processes. As of 6/30, the first two Kaizen events, 5S and discharge process, were completed.

Kaizen events involve key stakeholders including those who do the work and those who are affected by it: medical staff, registration clerks, pharmacists, nurses, social workers, patients and family members. Three representatives from the Patient Advisory Council have participated, and we have had patient representation at most events. A procedure has been developed so that after each Kaizen event, each attendee receives a one-on-one check-in to see if they have questions about what they learned and to make sure they are clear on their responsibilities and what comes next.

Planned VSM sessions for the first half of FY 12/13 include Psychiatric Emergency Services, Outpatient Pharmacy, and Emergency Department.

ACMC is undergoing a period of intense system transformation and this presents some challenges as well as opportunities to the Lean program. Implementation is underway or scheduled to start on an electronic health record (EHR) roll-out, an expense reduction initiative, the many DSRIP projects, two major construction projects and associated planning for moves. Medical center staff are being asked to rethink old ways of delivering care and to do so in a more efficient, cost-effective, and patient-centered manner.

DSRIP Semi-Annual Reporting Form

Category 1: Enhance Performance Improvement and Reporting Capacity

The multiple system-wide initiatives can lead to "change fatigue" among staff and conflict between change efforts as many priorities compete for attention and finite resources. In order to address this challenge, ACMC has established the STC. Currently ramping-up, the STC is designed to serve as a centralized clearinghouse for all ACMC change initiatives and set formal priorities for resource allocation. It will also help promote synergy among change initiatives.

To illustrate how the Lean process is working in our environment, here is one example of an improvement cycle from a Kaizen event associated with inpatient flow: In this Kaizen, the participants were focused on the critical pathway to move patients toward discharge. The group designed a checklist that included the key areas of financial counseling, nursing, physicians and social services; the checklist was intended to move with the patient through the system and support early discharge planning. When the new process was monitored, it was found that the form was only being used by one department, financial services.

The KPO director brought the leaders of each group together to do further education on the use of the form and problem-solve. In the end, it was decided that the form was not a useful intervention. However, through the process of collaboratively developing and testing the checklist, better workflows were clarified. The checklist was then used to ensure that the many steps identified by the team are part of the new EHR workflows. Staff will be better prepared to implement the EHR and the workflows when Soarian is launched, currently scheduled for February 2013.

The KPO is gathering and making use of data related to the A3 goals for each VSM. For example, the adult orthopedic clinic VSM is measuring length of time from referral to being seen in the clinic, patient satisfaction scores, orthopedic clinic discharge orders completed before provider leaves the room, next available appointments, and lead time for different classes of patients (pre-op, new, and existing).

The success of the Lean program so far reflects the engagement of staff at all levels. Executive leaders have demonstrated their commitment through participation in trainings, VSM, and Kaizen events and have set the tone for system-wide support. Directors and managers throughout the organization echo executive-level support and spread their enthusiasm to front-line staff. The commitment and participation of external stakeholders, including patients, families, caregivers and vendors has proved invaluable.

Several strategies are planned to ensure that Lean has a long-lasting effect on the system. Basic Lean concepts will be added to the annual competencies for staff. The KPO is developing a web-site for participants to be able to easily access tools and educational materials. Each event ends with a report-out, and all ACMC leaders are invited to come hear what has been developed by that team. Finally, the fact that the program is scheduled to last at least through 2015 means that there is a good opportunity to embed Lean culture in the organization.

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

REPORTING ON THIS PROJECT: *

Category 2: Expand Medical Homes

Below is the data reported for the DPH system.

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

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

Expand Medical Homes	
DY Total Computable Incentive Amount:	* <input type="text" value="\$ 3,920,000.00"/>
Incentive Funding Already Received in DY:	* <input type="text" value="\$ -"/>
<p style="margin-left: 20px;">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</p> <p>Process Milestone:</p> <ul style="list-style-type: none"> - 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. <p>Metric: Plan written and adopted.</p> <hr style="width: 50%; margin-left: 0;"/> <p style="text-align: center; font-size: small;">(insert milestone)</p>	
Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	* <input type="text"/>
Denominator (if absolute number, enter "1")	* <input type="text"/>
Achievement	<input type="text" value="Yes"/>
<p>If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:</p>	* <input type="text" value="Yes"/>
<div style="border: 1px solid black; padding: 10px;"> <p>Results: ACMC succeeded in developing and approving a "Connecting to Care" plan for connecting high priority patients to a medical home. The work plan lays out detailed steps needed to accomplish our goal of providing 50% of patients in the emergency department (ED) and specialty care clinics who need a medical home (as defined in DY7 plan) with a medical home assignment and an appointment to be seen within 60 days of referral by DY10.</p> <p>As with many of ACMC's DSRIP milestones, this milestone, while quite demanding on its own, represents only one aspect of the long-term goal of transforming our primary care centers into medical homes. ACMC, with its community safety net partners, began the process of moving toward creating medical homes during the first five-year Waiver demonstration period, the Coverage Initiative / Alameda County Excellence (ACE) Program. During that time, ACMC joined with the Community Health Center Network and the County Health Care Services Agency to develop a community-wide Panel Management Standard of Care and to begin the process of instituting the disease registry software (i2i Tracks) which forms the basis of our panel management program (see report on milestone Disease Management Registry Functionality). We still have work to do in order to design and build our medical home model. ACMC's Expanding Medical Homes milestone focuses on the urgent need to connect the patients who are most in need to a medical home.</p> <p>During DY7, in addition to developing the plan, a position for a medical home program manager was developed and posted. The medical home manager will lead the implementation of the plan, including regular reporting of patients seen in the ED or specialty clinics who do not have a medical home, fine-tuning and operationalizing the high risk criteria, further clarifying the processes by which these patients will be linked to a primary care medical home, and implementing a tracking database. Also during DY7, the panel management expansion was planned and implemented and is now fully operational. Our target provider panel size was determined (1350 patients) and the processes of "cleaning" the panel data to accurately reflect provider panels and finalizing the panel assignment protocol were underway (see the report on Disease Registry Functionality for details).</p> </div>	

DSRIP Semi-Annual Reporting Form

Category 2: Expand Medical Homes

The "Connecting to Care" plan was developed within the context of the multiple major system changes taking place at ACMC. It addresses the need to connect high priority patients—specifically in the emergency department and specialty care clinics—to a medical home where they can maintain continuity of care and receive preventive health support. The plan outlines strategies and activities that target patients with chronic and debilitating diseases that can often be managed more effectively in a medical home, thus preventing critical episodes and costly care. Transitioning these patients to primary care frees up the ED and specialty care services for those who do need emergency and specialty care. The plan also promotes system changes such as improving the timely availability of patient's health information to different care providers. It includes activities to develop information system tools that will enable us to identify high-risk patients and to target interventions and monitor results.

Because the position of medical home program manager was not yet filled, an experienced health planner was hired as a consultant to lead the planning process. Developing the plan was in itself a challenging task. We are aiming to move from a current state of multiple poorly coordinated units to a system that smoothly transitions patients from one level of care or department to another. To plan for this, it was necessary to identify and understand many complex processes that are currently used to attempt to connect patients to care.

The consultant interviewed more than 25 stakeholders, including physicians and line staff from the ED, ambulatory care and specialty care services, patient registration and financial counseling, etc. She attended meetings of the Clinical Implementation Work Group, a community wide group that is developing a common care transitions protocol for the safety net healthcare providers. Many individuals from across the system participated in the development of the plan and reviewed drafts; the final plan was approved by Ambulatory Care and the DSRIP Oversight Committee.

A major challenge to both creating the "Connecting to Care" plan and to achieving its objectives is the interdependence of the multiple changes we are making, and the need to make key decisions while some parts of the systems are not fully formed. For instance, proceeding with empanelment depends on the decision about panel size. Panel size depends in part on the level of acuity of the panels, which in turn depends on making complex decisions about prioritizing who will get priority services, which depends on the availability and analysis of accurate patient data. The electronic health record (EHR) and the associated financial, registration and scheduling modules are part of the infrastructure which is needed to facilitate implementation of this plan. Because we are in a transition state between electronic health IT systems, we had to plan for one set of processes for before EHR implementation, and another for after. For instance, in FY 12/13, the criteria for scheduling a priority appointment and assignment to a medical home for ED patients will be: an inactive patient (patient not seen in one of ACMC's primary care clinics in the last 18 months) seen in the ED who has never been assigned to or seen in a Medical Home And has a diagnosis of CHF, COPD, asthma or diabetes. After the EHR is fully operational, based on the experience in stage one and the capacity of the new EHR for reporting, we will develop an algorithm for stratifying patients by risk, employing predictive modeling using administrative data. High priority criteria may include clinical acuity; frequent ED visits for chronic conditions, e.g., COPD/asthma, chronic heart failure (CHF), and diabetes; multiple chronic conditions; cancer; psychosocial disorders; prioritization by provider recommendation.

Delays or problems with functionality of the EHR may affect timely implementation of the plan. We will want to make changes to the system to support the new processes, but most design changes have to wait until the basic implementation is complete.

Another barrier to successful implementation of the "Connecting to Care" plan is the availability of primary care. Primary care capacity has been a serious and consistent problem at ACMC; to be able to successfully connect more patients to a medical home, capacity must increase. ACMC is concurrently planning for expansion of primary care capacity, but the impact of that expansion will only be felt gradually. With limited availability of primary care, we had to come to agreement about which patients would be prioritized for enhanced support to get into care.

We have been exploring issues related to the prioritizing of patients for different levels of care. In June we held a colloquium (described in the report on our Chronic Care Management milestone) at which we heard from experts about issues related to caring for highly complex patients; we are planning a field trip to Denver Health Systems to learn more about their system, including their method of tiering patients for care.

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

REPORTING ON THIS PROJECT: *

Category 2: Expand Chronic Care Management Models

Below is the data reported for the DPH system.

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

- * The yellow boxes indicate where the DPH system should input data
- 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 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. <i>(insert milestone)</i>
Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	* <input type="text"/>
Denominator (if absolute number, enter "1")	* <input type="text"/>
Achievement	<input type="text" value="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:	
<div style="border: 1px solid black; padding: 10px;"> <p>Result: A retrospective utilization and financial analysis of the Hepatitis C and Pain Clinics was performed for the nine-month period of July 2011 through March 2012.</p> <p>The Hepatitis C Clinic opened in February 2011 and is held 2 days per week; there were 950 visits over the 9 month analysis period. The Pain Clinic opened in July 2011, and is held 3 days per week; there were 1,505 visits over the 9 month period. Both clinics have multidisciplinary teams that include, e.g., a physician's assistant, social worker, psychologist, and physical therapist.</p> <p>Updated visit numbers for the full year (DY7) show 2,064 total visits for the Pain Clinic for FY2012, and 1,306 visits for the Hepatitis C clinic.</p> <p>Summary of utilization and financial analysis: The overall payer mix for the two clinics for the nine month analysis period was 53% HealthPac, 30% Medi-Cal, 11% Medicare, 5% patient pay/charity and 1% private insurance. In April of 2012, the Highland clinics obtained Federally Qualified Healthcare Status (FQHC). We anticipate this will significantly increase reimbursement for both provider visits as well as eligible social work visits with the Pain clinic.</p> <p>When analyzed prior to the change in FQHC status, both clinics had a negative operating expense and contribution margin; however it is too early in the program to document patient outcomes and cost avoidance and therefore to assess overall return on investment. For instance, in Hepatitis C treatment, patients are on drug therapy for 48 weeks. Elimination of the virus is defined by a 'sustained virologic suppression' after 6 months of treatment. Thus it takes nearly 18 months after initiation of treatment to assess Hepatitis C treatment outcomes. A reasonable assessment of avoided emergency department visits and other utilization requires at least a year of medical history. Therefore, we plan to conduct a second phase analysis of utilization and financial impact. This will provide data to determine long-term sustainability of these services by examining costs that may have been avoided.</p> <p>Meanwhile, our experience in setting up these two clinics has informed our work to create programs to care for patients with frequent visits and chronic illnesses, including the HOPE Center for complex care, described below, and the development of the medical home model. The experience has re-emphasized the importance of team communication and relationships. We have also recognized the importance of the medical assistant and eligibility clerk with regard to welcoming and directing the patient through the clinic processes and keeping the patients engaged.</p> </div>	
* <input type="text" value="Yes"/>	

DSRIP Semi-Annual Reporting Form

Category 2: Expand Chronic Care Management Models

In terms of barriers, the pain clinic has been a great success and its services have been in high demand, to the extent that access for new patients is a challenge; as of the end of June the pain clinic was approaching maximum capacity.

The pain clinic follows a model of working intensively with a group of patients who receive extended intakes, medical visits at least monthly, as well as weekly psycho-social group visits and other therapy. The program lasts 3-6 months. The clinic is using some innovative pharmacologic interventions to help patients to avoid use of traditional full agonist opioids which can be addictive. An example is the use of buprenorphine for pain. With the use of buprenorphine, patients often can stabilize their pain with fewer side effects and reduced risk of addiction. This in turn enables them to better manage their care and to be transitioned out of the pain clinic, freeing capacity to see more patients in need of the services. In addition, to the extent we can move patients into normal care and self-management, the model will be more likely to be financially successful and sustainable.

However, there are some administrative barriers that must be overcome in order to use some of these drugs. The clinic staff has been successful in working out these challenges in some cases. We are planning to bring in a pharmacy tech to help navigate the treatment authorization challenges to obtain needed drugs for both clinics.

Finally, although it is not possible yet to analyze the financial impact of these services, we are including this case story to illustrate how these services impact patients' overall health and utilization of services.

Hepatitis C Clinic

Mr. P is a 50 year old gentleman co-infected with HIV and Hepatitis C. He was referred to the Hepatitis C clinic having attempted treatment several times. He is known to have advanced liver fibrosis and treatment of his Hepatitis C was imperative. Co-infected people progress to cirrhosis about four times faster than mono-infected, and Hepatitis C is now the leading cause of death in persons with HIV. Hepatitis C treatment is long and unpleasant. Common side effects include, but are not limited to, flu-like symptoms, fatigue, nausea, vomiting, headache, muscle aches, rashes, hair loss, depression or mania, insomnia, weakness, irritability, and severe anemia. Undaunted by prior poor results, he agreed to another attempt using a new treatment regimen. This new regimen would increase his chance for a sustained virologic response to about 50% and would include not only the same drugs that made him feel so lousy during his other attempts, but a new drug with its own set of side effects. We adjusted his HIV medicines to avoid dangerous drug interactions and he began another 48 week treatment attempt. As expected, it was extremely difficult. He suffered from extreme fatigue, nausea, insomnia, chronic sores in his mouth, anemia, weakness, headaches and an extremely pruritic rash. The virus responded to the new treatment, and he had undetectable levels of Hepatitis C at week 4 of treatment. He has remained aviremic throughout treatment and completed the 48 week course about 3 months ago. Now we have to wait. We will test whether the virus is still undetectable again at six months post treatment. If the virus remains undetectable we will declare him a sustained virologic responder, and cured of Hepatitis C. His liver damage will cease and in all likelihood improve over time. He will no longer have the risk factor that takes the lives of so many of our patients. He is an inspiration and has much to contribute to his community and this world. I look forward to seeing him get stronger and healthier and applaud his will to overcome this once incurable disease—Amy S.

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

*

Achievement Value

DSRIP Semi-Annual Reporting Form

Category 2: Expand Chronic Care Management Models

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

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

*

Denominator (if absolute number, enter "1")

*

Achievement

Yes

[If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:](#)

* Yes

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

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

Key details from the HOPE Center plan:

Mission: To improve the care of ACMC's most complex and vulnerable patients by replacing episodic high-cost interventions with longitudinal intensive outpatient care.

Vision: Through increased emphasis on care coordination and service integration for our system's sickest patients the HOPE Center can achieve:

- Reduced system costs by increased efficiency of care for complex patients
- Improved health outcomes for our most vulnerable patients
- Improved clinic flow and decreased congestion in outpatient clinics

Objectives:

- Identify patients at risk of highest cost and redundant care in the ACMC patient population
- Recruit 200 patients by end of FY2013, 400 patients by end of 2014 through a tiered process of selection combining case identification through data and physician referral
- Establish care model including interdisciplinary teams, personal care plans, care coordination, behavioral health integration, open access to and continuity of care
- Demonstrate improved processes by measurement of baseline and intervention patient data for hospitalization rates and ED utilization rates as well as other direct health markers
- Incorporate new funding mechanisms and federal and state incentives programs for care of high-risk populations to ensure continued sustainability of plan

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

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

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

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

DSRIP Semi-Annual Reporting Form

Category 2: Expand Chronic Care Management Models

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

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

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

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

*

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
 DPH SYSTEM: Alameda County Medical Center
 REPORTING YEAR: DY 7
 DATE OF SUBMISSION: 9/29/2012

REPORTING ON THIS PROJECT: *

Category 2: Redesign to Improve Patient Experience

Below is the data reported for the DPH system.

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

- * The yellow boxes indicate where the DPH system should input data
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Redesign to Improve Patient Experience	
DY Total Computable Incentive Amount:	* <input type="text" value="\$ 3,920,000.00"/>
Incentive Funding Already Received in DY:	* <input type="text" value="\$ -"/>
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. <i>(insert milestone)</i>
Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	* <input type="text"/>
Denominator (if absolute number, enter "1")	* <input type="text"/>
Achievement	<input type="text" value="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:	* <input type="text" value="Yes"/>
<div style="border: 1px solid black; padding: 10px;"> <p>Results: This year's activities and accomplishments specific to the nursing communication goal include the formal adoption of the AIDET model for improved nurse to patient communication, development of the curriculum and education plan to support model, and beginning the training of permanent nursing staff in the use of AIDET and Hourly Rounding using the newly adopted model.</p> <p>The AIDET training curriculum consists of a 4 hour skill building, assessment-based program designed to educate organizational leaders on basic customer service skills using the StuderGroup AIDET model (Acknowledge, Introduce, Duration expected, Explanation, Thanks). The learning objectives are for participants to 1) understand why AIDET leads to higher quality of care, reduction in patient anxiety, and improvement in patient and employee satisfaction; 2) gain an understanding of AIDET and be provided with tools to ensure AIDET is implemented in the workplace; and 3) demonstrate their ability to train their staff on customer service using the AIDET framework.</p> <p>The training uses a variety of adult-learning techniques such as videos, didactics, role plays and individual teaching practice. Participants receive materials for training their staff, including PowerPoint, assessment form, and pocket cards. To ensure on-going training and account for staff turnover, the customer service training will be incorporated into annual competencies, and new leaders will complete the train-the-trainer and competency assessment program.</p> <p>The DSRIP Patient Experience milestone is one part of a much larger effort that is underway at ACMC. We focused our DSRIP objective on nursing communication because that is fundamental to the overall improvement of the patient experience. The process milestones for DY8 and DY9 are to complete training of 85% of permanent inpatient nursing staff on the communication model and standards, and to complete formal evaluation of communication skills competencies for 85% of permanent inpatient nurses as part of their annual evaluation. The DY10 DSRIP goal is to improve nurse communication scores on HCAHPS patient experience survey by 12%, by the last quarter of DY10, as compared to the calendar year 2010 baseline score. A 12% improvement over the 2010 calendar year average score of 63.83 in nursing communication top box scores would be a score of 71.49.</p> </div>	

DSRIP Semi-Annual Reporting Form

Category 2: Redesign to Improve Patient Experience

We are monitoring our patient experience data closely. For DY7 (FY2013) we are showing a very slight positive trend, and we expect that sustained attention will yield sustained improvement over time.

July 2011 - 65
Aug 2011 - 69
Sep 2011 - 64
Oct 2011 - 64
Nov 2011 - 62
Dec 2011 - 63
Jan 2012 - 62
Feb 2012 - 67
Mar 2012 - 65
Apr 2012 - 63
May 2012 - 71
Jun 2012 - 68

We have a long way to go to reach our DY10 goal, and the DSRIP milestones alone will not get us there. During DY7, ACMC created and filled a position for Director of Patient and Family-Centered Care. This new leader, who started in June 2012, is responsible for developing and leading the implementation of a Patient & Family Centered Care model throughout ACMC. The success of this will be measured in part by the improvement of patient experience scores for the institution overall.

Other activities related to improving patient experience include our participation in the PExT learning collaborative, which is described in the Performance Improvement project report.

We also refined our institution-wide reporting mechanism of patient experience data. Patient experience survey results are prominently displayed on the ACMC Intranet, with detailed reports available by service lines: Inpatient, Emergency, Behavioral Health, Ambulatory Surgery, Clinics, Outpatient Testing & Treatment, and Inpatient Rehabilitation. Organizational patient experience results are regularly reported at these monthly meetings: Medical Executive Committee, Operations Councils, and Quality Council, and system-wide managers' meetings.

A challenge for improving our patients' satisfaction is the need to convey the importance of this project to key stakeholders at all levels of the organization. At ACMC many critical programs and urgent improvements are underway simultaneously, including new buildings, expansion of services, and implementation of the EHR. This makes it difficult to maintain focus on any one project. Another challenge is that many long-time staff members are accustomed to "business as usual," and some are skeptical that change is possible.

Our strategies for addressing these challenges and sustaining improvements include:

- The hiring of the new dedicated Director Of Patient And Family-Centered Care to lead a patient experience program and creation of an organizational patient and family centered care road map
- Continuing with the PExT collaborative efforts through January 2013 with mandatory coaching, learning opportunities, webinars and training sessions, including hosting PExT Design and mapping session for all collaborative participants
- Enhancing customer service skills through the creation of a service recovery policy and tool kit, and related nursing training in service recovery
- Reviewing and amending hospital policies relevant to patient experience to be more patient/family centered
- Expanding customer service training for the organization overall.
- Ongoing acknowledgement and recognition for employees and leaders who support this project

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

REPORTING ON THIS PROJECT: *

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

Below is the data reported for the DPH system.

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

- * The yellow boxes indicate where the DPH system should input data
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Improve Patient Flow in the Emergency Department/Rapid Medical Evaluation

DY Total Computable Incentive Amount: *

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

[If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:](#) *

Results: APMC has conducted and reported on four improvement interventions aimed at our DY9 goal of reducing overall ED length-of-stay for both low acuity patients (level 4 & 5) and for patients admitted to the hospital by 20% compared to baseline (APMC FY 2010).

The Emergency Department (ED) has been implementing several projects in order to reduce length of stay and has shown great improvements in the reduction of LOS for low acuity patients. Overall average length of stay for low acuity patients in FY 11/12 was 188 minutes, a reduction of 19% compared to our FY 09/10 baseline of 232 minutes. However, length of stay for admitted patients has not improved, despite our efforts. Average length of stay for admitted patients in FY 11/12 was 14:42.

The four improvement projects reported on for DSRIP DY7 were 1) the addition of an Intake Nurse; 2) Mini-Registration; 3) SWAP; 4) Stable Admission Order Sets.

The first of the four ED flow projects was piloted in the fall of 2011 and has now been fully implemented. An intake nurse replaced the registration clerk as a patient's first point of contact in the ED; the nurse conducts a brief assessment of the patient to identify acuity and then directs them to the appropriate area of care. Low acuity patients are directed into the Fast Track area where they can be seen and discharged in a shorter amount of time. The idea being tested is whether a "rapid-sort" of low and high acuity patients will allow for both groups of patients to move through the ED more efficiently. So far we have seen improvement for low acuity but not for high acuity patients.

The second improvement project, Mini-Registration, aims to shrink the average length of stay for all patients by reducing the time it takes for them to be entered into the ED's database, Wellsoft, and assigned to a provider. With the mini-registration, a patient enters the emergency room and is immediately seen by the Intake Nurse and sorted into Fast Track (low acuity) or Non Fast Track. After this "rapid-sort", patients are mini-registered at the registration desk and sent to their respective waiting area. Mini-registration is a condensed version of the full registration process and requires only the crucial pieces of patient information necessary to start a patient in the system.

The third improvement project, SWAP, aims to make more efficient and timely use of available ED beds and to reduce wait time for patients. SWAP distinguishes between level 3 "horizontal" patients (needs to be lying down) and level 3 "vertical" patients (does not need to be lying down). Vertical patients, who are typically waiting for lab results or other services that do not require them to be in a bed, are either moved out of an ED bed and into a designated SWAP waiting room so that the bed can then be used by another patient. When the patient needs to be seen by a physician again, they are moved back into a bed or into a SWAP consultation room if only a brief assessment, education, or follow-up is needed. SWAP guidelines were piloted in November of 2011, and a one-day SWAP trial was conducted to test the procedure and make adjustments prior to the go-live on March 14th. A plan for education of staff for ED-wide implementation of SWAP was developed. Several PDSA cycles resulted in refinements of the process. ED-wide SWAP education of staff began in the end of May and will continue over the next 3-5 months.

DSRIP Semi-Annual Reporting Form

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

Our fourth improvement project directly addresses the goal of reducing length of stay for ED patients admitted to the hospital. The stable admission orders pilot changes the workflow such that the full evaluation of stable patients who have already been accepted for admission takes place on the inpatient floor rather than in the emergency department. During the day shift, when using the stable admission orders procedure, the resident writes skeletal admission orders for patients who are clearly stable so that the patient can be transferred to the appropriate level of care sooner. Once transferred to a hospital bed, the intern completes their full evaluation.

This intervention is the result of a collaborative process that involved the leadership of the Emergency Department, Nursing, and Internal Medicine. The original plan was developed after focus group sessions with residents, and vetted by the leadership of the Department of Medicine, the Department of Emergency Medicine, and Nursing. Residents were educated about the new process at multiple noon conferences, and are periodically reminded. The pilot for stable admission orders began in February 2012. The stable admission orders process has not yet become routine for new interns and improvement efforts are now aimed at increasing the frequency of use of the stable admit process so that we can learn more from the data we are collecting.

The success of the ED projects is the result of strong participation from stakeholders in ongoing improvement projects. In addition to an ED Nurse Committee focused on ED Flow, the ED has a committee of physicians, nurses, residents, registration staff, and other relevant stakeholders that meets weekly to address issues of flow throughout the ED and to test and implement new improvement projects.

In all of the ED Flow improvement projects, staffing vacancies have been a big barrier. There are multiple RN vacancies as well as ED Techs and PAs, and it is difficult to fill these vacancies quickly. To combat these issues, the ED has begun to strategize with Human Resources to expedite the hiring and on-boarding process for new employees.

Another challenge is that staff education is time-consuming. It will take approximately 5-6 months to complete the SWAP education due to multiple competing priorities and a lack of staff resources.

The effort to reduce LOS for patients being admitted is inherently more challenging than reducing LOS for low-acuity patients, because it involves the flow through the whole system, and requires coordination across ED and inpatient departments and staff.

Several DSRIP-related projects will contribute to solving this problem. A Lean project targeting inpatient flow was completed in DY7, and another focusing on the ED is starting in the first half of DY8. The Care Transitions milestone report describes many activities that are aimed at improving discharge planning and flow on the inpatient side.

The inpatient and ED medical staff will be meeting regularly in DY8 to work together on reducing ED length of stay for admitted patients and to streamline and standardize the admission process.

Amidst all of the work that the ED flow teams have been doing, there has been improvement in data availability and utilization. Increased data collection has allowed the ED team to redefine metrics and goals to better measure the impact of changes, and to identify new cycles of change. Weekly dashboards have been created to reflect progress. The triage process has been modified in order to standardize how patient information is collected and to improve times.

In addition to the four projects focused on ED Flow, through on-going improvement projects the ED has also decreased "walk away" patients from 9% to 5%, and implemented a smaller, parallel process to the Intake Nurse that has allowed patients to receive EKGs within 10 minutes of arriving in the ED.

In order to ensure sustainability and efficacy, the roles and responsibilities for intake/treatment RN's, ED Techs, Physicians, and PA's have been clarified and two new physician assistants have been hired using DSRIP funding. The Fast Track process implemented in 2011 is being assessed in an effort to standardize processes.

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: 9/29/2012

REPORTING ON THIS PROJECT: *

Category 2: Implement/Expand Care Transitions Programs

Below is the data reported for the DPH system.

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

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- The black boxes indicate Milestones and will automatically populate and flow to summary sheets
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Implement/Expand Care Transitions Programs

DY Total Computable Incentive Amount: *

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

[If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:](#) *

Results: The Patient Call Manager (PCM) is a program to contact discharged patients by phone 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. After a successful pilot, the program was expanded to all patients discharged from Highland inpatient units including maternal/child health.

In DY7 out of 5,878 patients who were discharged from Highland inpatient care, 84.42% were contacted and the call was completed, 12.71% were found to be wrong numbers, 2.36% were do-not-call requests, and 0.51% of patients were dropped due to time or multiple unsuccessful attempts.

One of the main challenges for the PCM manager is maintaining consistent staffing. The program uses nurses that are on "light-duty" due to a medical condition to make the follow up calls. We are considering adding a regular position to the team. Another limitation to the program is that the calls are only made Monday through Friday. We plan to extend the follow-up call schedule to seven days.

Our efforts to improve Care Transitions began with the Patient Call Manager, but have gone well beyond that initial effort. To address the larger challenge of care transitions, ACMC formed a Reducing Readmissions Harm Reduction Team (HRT) in Spring of 2010. The members of the team include a wide range of stakeholders from various disciplines and departments: physicians, nurses, administrators and others; representing ambulatory care, the inpatient service, patient registration, the quality department, etc. The HRT decided to join the Avoiding Readmissions Collaborative (ARC--described in the Performance Improvement Project milestone report). We applied for and were awarded an ARC Planning Grant of \$25,000 in February 2011, funded by the Gordon and Betty Moore Foundation. Guided by the ARC process and with the assistance of our ARC consultant, the HRT first went through steps to understand the problem. The team conducted chart reviews, administered key informant questionnaires from staff and patients and analyzed ACMC data on readmissions. We participated in learning sessions and reviewed literature.

In October 2011, the HRT completed and submitted its reducing readmissions plan. The ARC plan explicitly builds on several ACMC DSRIP projects (e.g., expanding medical homes and primary care capacity) that address the system goal of improving current care transition systems to better enable patients to care for themselves and to avoid preventable readmissions. Based on our understanding of the challenges of our system, the plan calls for a two-pronged approach to reducing preventable readmissions: improvements to the basic system of care and special interventions for patients who are at especially high risk for readmissions.

Category 2: Implement/Expand Care Transitions Programs

The ARC plan formed the basis for a successful proposal to the Gordon and Betty Moore Foundation to support the key evidence-based intervention of creating a High Risk Care Transitions Team modeled on Project ReEngineered Discharge (RED). The grant began in June, 2012.

During DY7, the HRT engaged in several improvement activities in addition to developing the plan.

- We used Smart Orders, a web-based tool that creates admission checklists (order sets) to develop and test order sets to guide clinicians in best practices for reducing readmissions, such as using screening criteria to identify high risk admissions
- We conducted a winter awareness campaign to educate staff (residents, nurses, social workers) on how to reduce readmissions
- A subgroup investigated the process of making post-discharge appointments at one of ACMC's free-standing health centers, identifying what the key barriers were and making recommendations for improving the process
- Participating hospitalists drafted a toolkit for teaching residents best practices for avoiding preventable readmissions, including teach-back concepts, the characteristics of a good discharge summary and a checklist, assessing for discharge readiness, referrals, etc. This will be incorporated into residency training starting this academic year

One of the key activities we used to drive our ARC investigation was recurring cycles of testing of a Nurse Care Navigator modeled on the Project RED program as an intervention on the inpatient wards. With the help of summer nursing interns we developed materials for a pilot test and conducted repeated cycles working toward a larger scale pilot. Through these PDSA cycles, we were able to test the feasibility of different aspects of the intervention, which prepared us for full implementation of the Care Transitions Team.

We conducted the larger scale version of the Nurse Care Navigator pilot program from 12/19/2011 to 2/29/2012. The goal of the pilot project was to determine if the addition of a Registered Nurse Care Navigator (NCN) to the inpatient health care team would reduce hospital readmissions. The NCNs were at Highland Hospital seven days a week during the pilot study period. The NCNs coordinated and implemented interventions designed to reduce readmissions, modeled after Project RED. Specific NCN interventions included disease education, screening for cognitive impairment, medication adherence coaching and helping patients and families to understand the aftercare plan.

The target population was patients with congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) or asthma. 49 patients participated in the pilot study. The 30-day readmissions rate among patients in pilot study was very low--only 1 patient out of the 49 was readmitted within 30 days post-discharge. This is in sharp contrast with the average rate for 30-day readmissions for FY 11/12, which was 11%. Without claiming causation, we can also report that there was a notable dip in the 30 day readmission rate for the hospital overall during this period, which is unusual for the winter months.

A focus group of pilot study patients was held in April. Five patients participated; all thought that their health outcomes were better because of the education they received from NCNs. The focus group indicated that NCN interventions were helpful because they resulted in deeper knowledge regarding their COPD and CHF conditions and how to prevent relapse; improved understanding of diet, medication management and better self-care in general.

In another example of the use of PDSA, a pilot was conducted in April and May of 2012 of a transitional care pharmacist. Compared to the control group (usual care), patients receiving care from the transitional care pharmacist had fewer readmissions at 30-days post-discharge, and improved post-discharge follow-up attendance. Based on this pilot, funding for a transitional care pharmacist position was approved through the DSRIP Oversight Committee. The pharmacist will conduct medication reconciliations as well as provide medication education to high risk patients, their families and caregivers. This role will be fully integrated with the care transitions program.

Finally, we are actively working with other members of the Alameda County safety net healthcare system, under the auspices of the local LIHP program, in a cross-sector committee called the Clinical Implementation Work Group. This group is focusing specifically on improving the care transitions process across the system. The aim is to create a standard discharge and follow-up process with shared responsibility between the hospital and medical home, ensuring that every hospital discharge occurs with clear communication transfer to the patient and medical home and that the medical home has a follow-up procedure in place.

Many challenges need to be met in order to successfully implement Project RED and the Care Transitions Team program. As noted elsewhere in this report, the concurrent implementation of the EHR, as welcome as it is, complicates process improvements. The EHR will need to be modified to support the evidence-based practices for better care transitions.

A critical step forward was the hiring of a Utilization and Care Management director who is experienced in directing care transitions programs. He will be leading care transition system change efforts during DY8 and forward.

The care transitions project links to the medical home project, and the new medical home program manager will be working closely together with the Utilization and Care Management director to coordinate these system-level transformation efforts. These programs also link to the Emergency Department Flow project, and to our Lean initiatives. All of these change efforts need to be coordinated and aligned. This will be one of our challenges during DY8.

We will also be tracking the impact on cost of care; we anticipate that the reduction in utilization of the ED, more efficient discharges and prevention of readmissions will lead to cost savings and make the program sustainable.

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

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:	* \$ 3,324,750.00
Incentive Funding Already Received in DY:	* \$ 3,324,750.00
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
<div style="border: 1px solid black; padding: 5px;"> <p>Results: 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 a multidisciplinary working group to develop a standardized approach to implementing CG-CAHPS across all CAPH members.</p> <p>In the period January through June of 2012, we designed and made decisions related to the sampling method to be used for CG-CAHPS. On April 1st, the stratified sampling required for clinic level sampling was implemented.</p> <p>Results for the first ten months of surveys have remained very stable without significant decreases or improvements in our top box score for "Rate Provider 9 or 10." The top box scores for June, 2012 for the measure components were:</p> <ul style="list-style-type: none"> - Rate Provider 9 or 10 = 48 - Access to Care = 24 - Test Results = 48 - Provider Communication Quality = 74.5 - Office Staff Quality = 83 <p>One of the challenges we are facing in reporting on CG-CAHPS results is that the vendor does not consider "Shared Decision-Making" a standard part of CG-CAHPS. Thus, although we are including these questions in our patient surveys, the vendor's formatting does not present these questions in a way ACMC can determine the results. ACMC is working with our CG-CAHPS vendor to improve the reporting of the "Shared Decision-Making" questions. Ideally, the vendor will create a user interface in the vendor's online database that would report the results in the same format as the other domain questions are reported. If this cannot be accomplished, customized reports will be sent to ACMC.</p> <p>Another concern we have had as we develop this reporting process is the fact that clinic-level sampling includes every provider as part of the pool for calculating sample size, regardless of whether they saw one patient or hundreds. In part because we are a teaching institution, the number of providers fluctuates from month to month, which makes the sample number vary as well. ACMC has spoken with experts at SNI and Press Ganey, our vendor. Both have indicated that this situation is not unique to ACMC and as long as the organization is diligent in checking the sampling it should not cause any problems. We are developing a plan to monitor sampling to ensure provider population and the corresponding sample size is set appropriately.</p> <p>Program Improvement Efforts: It is clear that we have a long way to go to improve these scores, but the first step is having the data. In DY7 ACMC hired a Director of Patient and Family-Centered Care who will lead efforts to improve patient experience scores. (Please see the narratives for "Redesign to Improve Patient Experience" and "Enhance Performance Improvement Capacity" for more details).</p> </div>	

DSRIP Semi-Annual Reporting Form

Category 3: Patient/Care Giver Experience *(required)*

The link to these data and other patient experience scores are in a prominent place on the ACMC intranet, and, as described in the Patient Experience milestone report, we have been communicating the data to the staff in many ways. Results are reported and discussed at the following monthly meetings: Medical Executive Committee, Ambulatory Care Operations Council, Ambulatory Care Physicians, and Quality Council.

The Ambulatory Care Services Division has designated an existing staff member to be the internal AIDET/Customer Service trainer. He has conducted AIDET/Customer Service trainings and assessments with the staff at the ambulatory care sites. We regularly monitor and promote the use of AIDET with the staff. We also have brainstormed other ideas to improve the patient experience such as asking patients to think about and write down questions for their providers while they are in the waiting room, surveying patients about their experience as part of our reminder calls, and we will be testing these ideas in the coming months.

Achievement

Yes

Achievement Value

1.00

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
 DPH SYSTEM: Alameda County Medical Center
 REPORTING YEAR: DY 7
 DATE OF SUBMISSION: 9/29/2012

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:	* \$ 3,324,750.00
Incentive Funding Already Received in DY:	* \$ -
Report results of the Diabetes, short-term complications measure to the State (DY7-10)	
Data Collection Source	* Data warehouse
Numerator	* 18.0
Denominator	* 5,368.0
Rate	0.34
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):	
<p>ACMC is reporting that 0.3% of patients age 18-75 years with diabetes who have visited ACMC primary care clinics two or more times in FY 10/11 have received an inpatient discharge with an ICD-9 principal diagnosis code for diabetes short-term complications within FY 11/12 (DY7)</p> <p>Method: A team that included the Medical Director of Ambulatory Care, the Chief Medical Information Officer, the Clinical Data Coordinator and our Health Information System (HIS) consultant met over several months to review the measures and to determine the most effective means to report the data. Trial reports were generated and were reviewed by the group. Further testing and refinements of the report were made until the group was satisfied that we had the most accurate report possible.</p> <p>Denominator: The list of patients that qualify was obtained from the HIS. Numerator: The list of patients who received an inpatient principal diagnosis code for diabetes short-term complications during the demonstration year also came from the HIS.</p> <p>With regard to the rate that is being reported, we have some concern that it may be under-representing the number of our patients with diabetes who have been hospitalized. Since many patients are admitted with multiple conditions and the measure reports on principal diagnosis, some patients with diabetes might be admitted without a principal code for diabetes, and would not be included. Any patients who were admitted to other hospitals would also not be included in this report.</p> <p>Related program improvement efforts: The Ambulatory Care Services Division has a Quality Steering Committee which will review the DSRIP data semi-annually. Members of the committee include medical staff, nurses, administrators, Ambulatory Care leadership, and health educators.</p> <p>The Panel Management program, with the data provided by i2i Tracks, our disease management registry (see report on Disease Management Registry for more details) is a primary strategy for diabetes care improvement.</p>	

DSRIP Semi-Annual Reporting Form

Category 3: Care Coordination (required)

Physician and staff engagement for diabetes care has contributed to a sustained effort to improve diabetes care over many years. We have several groups that are working on different aspects of diabetes care. The Chief of the medical staff, a Clinic Medical Director, Health Education Manager, and members of the Health Education team make up a diabetes work group which is developing standards of care in health education and treatment of type 2 diabetes. When completed, these standards will be posted on the ACMC Intranet and disseminated in the ambulatory clinics. A diabetes work group specific to Highland's Adult Medicine Clinic meets monthly to develop improvement projects. Through this group, a medical assistant in the Highland adult medicine clinic has been trained to do foot inspections and monofilament examinations for all patients with diabetes at the beginning of their outpatient visit.

Through the Clinical Quality and Disease Management Collaborative with SNI from 2008-2010, core diabetes care work groups at each clinic were formed that include both physicians and their care teams. Teams used the PDSA model to modify service delivery to enhance clinical outcomes. A variety of strategies, including point of care, a health coach intervention, and group medical visits are practices still in place.

In a new program that was pilot-tested and launched this year, a transitional care pharmacist working in the acute care hospital at Highland Campus will provide education on medications, insulin dosing, etc. to patients with diabetes who are hospitalized (see the Care Transitions milestone report for details).

Achievement

Yes

Achievement Value

1.00

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

Data Collection Source

* Data warehouse

Numerator

* 2.0

Denominator

* 5,368.0

Rate

0.04

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

ACMC is reporting that 0.04% of patients age 18-75 years with diabetes who have visited ACMC primary care clinics two or more times in FY 10/11 have received an inpatient discharge with and ICD-9 principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication within FY 11/12 (DY7).

Method:

A team that included the Medical Director of Ambulatory Care, the Chief Medical Information Officer, the Clinical Data Coordinator and our Health Information System (HIS) consultant met over several months to review the measures and to determine the most effective means to report the data. Trial reports were generated and were reviewed by the group. Further testing and refinements of the report were made until the group was satisfied that we had the most accurate report possible.

Denominator: The list of patients that qualify will be obtained from the HIS.

Numerator: The list of patients who received an inpatient principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication during the demonstration year will also come from the HIS.

With regard to the rate that is being reported, we have some concern that it may be under-representing the number of our patients with diabetes who have been hospitalized. Since many patients are admitted with multiple conditions and the measure reports on principal diagnosis, some patients with diabetes might be admitted without a principal code for diabetes, and would not be included. Patients who were admitted to other hospitals would also not be included in this report.

Related program improvement efforts:

ACMC has a weekly diabetes specialty clinic for newly diagnosed patients as well as those whose disease is not well-controlled. About 20-30 patients receive treatment and diabetes education at each session. The clinic has led the way for diabetes treatment at ACMC, and has demonstrated that a multidisciplinary educational and self-management approach to diabetic patients can result in improved control and outcome measures. This has created a foundation for chronic disease management at ACMC using the Chronic Care Model and panel management.

DSRIP Semi-Annual Reporting Form

Category 3: Care Coordination (required)

The diabetes clinic has both registered nurse (RN) and dietician (RD) Clinical Diabetes Educators (CDEs) who work closely with patients with poorly controlled diabetes. Each adult medicine clinic has an RN CDE care coordinator who works with the patients and the clinician to prevent comorbidities from developing. In addition, diabetes education groups are held weekly in both English and Spanish. The diabetes clinic is currently reaching out to type 1 diabetics in order to facilitate behavior changes at an early age. All type 1 diabetics are referred to an RN CDE, and an LCSW is in the process of developing a type 1 support group.

Beginning two years ago, cameras were placed at all adult medicine sites so that digital retinal screening can be completed for all diabetic patients. Using information from the retinal screenings, we can now prioritize referrals to the ophthalmology clinic. And thanks to our partnership with the UC Berkeley School of Optometry, access to optometry services has more than doubled: In FY 09/10 the optometry clinic had 2,899 patient encounters and in this most recent demonstration year (DY7) they saw 6,590 patients (see report on Expanding Specialty Care milestone). The optometry clinic staff members are utilizing i2i Tracks health registry reports to increase the rate of screening for patient with diabetes by finding patients who are overdue for a retinal screening.

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: 9/29/2012

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:	* \$ 3,324,750.00
Incentive Funding Already Received in DY:	* \$ -
Report results of the Mammography Screening for Breast Cancer measure to the State (DY7-10)	
Data Collection Source	* Data warehouse
Numerator	* 240.0
Denominator	* 400.0
Rate	60.00
Provide an in-depth description of milestone progress as stated in the instructions. (If no data is entered, then a 0 Achievement Value is assumed for applicable DY. If so, please explain why data is not available):	
<p>. ACMC is reporting that 60% (240/400) of female patients age 50-74 who have visited ACMC primary care clinics two or more times in FY 10/11 had a mammogram screening for breast cancer within 24 months prior to the end of FY 11/12.</p> <p>Method: A team that included the Medical Director of Ambulatory Care, the Chief Medical Information Officer, the Clinical Data Coordinator and our Health Information System (HIS) consultant met over several months to review the measures and to determine the most effective means to report the data. Trial reports were generated and were reviewed by the group. Further testing and refinements of the report were made until the group was satisfied that we had the most accurate report possible.</p> <p>ACMC is currently transitioning to an electronic health record, but until the EHR is in place, we rely on multiple systems for reporting data. In addition to the HIS, ACMC uses i2i Tracks, a population health management system that aggregates data from different sources and generates disease registry reports.</p> <p>Numerator: Multiple information systems were reviewed for a mammography screening procedure completed between 7/1/2010 and 6/30/2012. For patients that attend Highland or Eastmont Primary Care Clinics, completed mammograms will be available in one or more of these systems: 1) i2iTracks - Health Registry 2) OAS/Gold 3) Syngo-Imaging Patients that attend Newark or Winton Primary Care Clinics may have mammogram procedures documented in the systems mentioned above. However, they are usually referred to a more local outside provider to receive this service. If there was no documentation in ACMC's internal information systems, we reviewed the following web-portals to determine if the procedure was completed and the patient met the criteria for compliance: 4) Nor-Cal Imaging 5) St. Rose Hospital Denominator: The list of patients that qualify was obtained from the HIS. A sample of 400 patients was randomly selected to become the denominator for this measure.</p>	

Category 3: Preventive Health (required)

An audit tool was utilized to document the source of the procedure and the date it was last performed. If a mammogram was unavailable using the electronic sources mentioned above, the patient's paper Medical Record was reviewed to determine if the patient met the criteria for compliance.

Related program improvement efforts:

All eligible female patients registered with an ACMC primary care clinic are enrolled in the Cancer Detection Program: Every Woman Counts (CDP:EWC) for free annual clinical breast exams and mammograms. To be eligible, patients must be over 40, uninsured or underinsured and have income at or under 200% of the federal poverty level. We send annual reminder letters to registered patients to encourage them to schedule a mammography appointment. We also reach out to community clinic-based providers that don't have mammography capability to invite referrals to ACMC for cancer screening.

Due to the high volume of referrals, we have added a weekly Saturday clinic at Highland for Mammography screening. With this added capacity, the mammogram schedule is less frequently backed up and it is usually possible for women to be sent directly from the clinic to radiology for diagnostic breast screenings on the same day. The wait for routine mammogram screening is generally no more than one week.

Currently mammography is not being offered at the Eastmont Wellness Center since the radiology machine was removed from service, resulting in patients having to travel farther for services. Funding for two new mammography machines has been approved, and we are in the process of acquiring the new machines. We look forward to resuming mammography services at Eastmont and beginning to offer this service at the Newark Wellness Center in the next 6 months. This will expand access for our patients throughout the western part of the county.

The panel management program, with the data provided by i2i Tracks, our disease management registry (see report on Disease Management Registry for more details) is a primary strategy for preventive care in the adult medicine clinics at ACMC. As part of the panel management program, a patient's need for a mammography screening is included in the patient visit summary. Panel management coordinators prompt physicians when the mammogram or other interventions are due.

Medical assistants at the clinic level have been given access to and trained to use the radiology appointment system in order to schedule mammograms while the patient is still at the clinic. This makes it much easier for the patient to follow-through and to get the needed screening.

In addition, we are developing basic standing orders for mammography, diabetes, and vaccinations; these will be instituted in the next year.

Achievement

Yes

Achievement Value

1.00

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

Data Collection Source

* Data warehouse

Numerator

* 3,325.0

Denominator

* 11,200.0

Rate

29.69

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

ACMC is reporting that 29.69% of patients age 50 and older who have visited ACMC primary care clinics two or more times during FY 10/11 have received an influenza immunization during the flu season of FY 11/12 (9/1/2011-2/29/2012).

Method:

A team that included the Medical Director of Ambulatory Care, the Chief Medical Information Officer, the Clinical Data Coordinator and our Health Information System (HIS) consultant met over several months to review the measures and to determine the most effective means to report the data. Trial reports were generated and were reviewed by the group. Further testing and refinements of the report were made until the group was satisfied that we had the most accurate report possible.

Category 3: Preventive Health (required)

ACMC is currently transitioning to an electronic health record, but until the EHR is in place, we rely on multiple systems for reporting data. In addition to the HIS, ACMC uses i2i Tracks, a population health management system that aggregates data from different sources and generates disease registry reports.

Numerator: The list of patients meeting criteria for compliance was generated by the billing information (ICD9/CPT) available in the HIS. A report of patients that have documentation for an influenza vaccination during the specified flu season was also obtained from i2iTracks and was cross-referenced with the initial report. This served as a secondary source for the numerator in order to capture flu shots that were received elsewhere and were documented in the Disease Management Registry.

Denominator: The list of patients that qualify was obtained from the HIS.

Related program improvement efforts:

Data collection on flu immunization was a challenge for us last year, in part because our available reports were based on billing data, not clinical documentation. As of this writing, three of the four outpatient clinics are now using an electronic health record, so in the future we will be able to report based on clinical documentation for these clinics. Reporting will continue to be a challenge for the hospital-based clinics that are not yet on the EHR.

The panel management program, with the data provided by i2i Tracks, our disease management registry (see report on Disease Management Registry for more details) is a primary strategy for preventive care in the adult medicine clinics at ACMC. As part of the panel management program, a patient's need for a flu vaccine is included in the patient visit summary. Panel management coordinators prompt physicians when the flu vaccine or other interventions are due.

Using panel management, we are working to do a better job capturing when a patient is vaccinated at another facility and reflecting that in our data. The physician indicates when patients are vaccinated at another facility, which is then recorded in the registry to help guide future visits.

Finally, we have recently developed standardized procedures that will allow us to run vaccination clinics without requiring a provider's signature or visit. We anticipate this will improve our vaccination rates.

Achievement

Yes

Achievement Value

1.00

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
 DPH SYSTEM: Alameda County Medical Center
 REPORTING YEAR: DY 7
 DATE OF SUBMISSION: 9/29/2012

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	* Data warehouse
Numerator	* 1,430.0
Denominator	* 5,368.0
Rate	26.64

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

ACMC is reporting that 26.64% of patients age 18-75 years with diabetes who have visited ACMC primary care clinics two or more times in FY 10/11 had their most recent LDL-C level in control [<100 mg/dl] in FY 11/12 (DY7).

Method:

A team that included the Medical Director of Ambulatory Care, the Chief Medical Information Officer, the Clinical Data Coordinator and our Health Information System (HIS) consultant met over several months to review the measures and to determine the most effective means to report the data. Trial reports were generated and were reviewed by the group. Further testing and refinements of the report were made until the group was satisfied that we had the most accurate report possible.

ACMC is currently transitioning to an electronic health record, but until the EHR is fully implemented we rely on multiple systems for reporting data. In addition to the HIS, ACMC uses i2i Tracks, a population health management system that aggregates data from different sources and generates disease registry reports.

Denominator: The list of patients that qualify was obtained from the HIS.

Numerator: The list of patients who received an LDL test during the demonstration year was obtained from i2iTracks. This report was cross-referenced with the list of eligible patients to obtain the number of patients who are in compliance.

Related program improvement efforts:

ACMC has a weekly diabetes specialty clinic for newly diagnosed patients as well as those whose disease is not well-controlled. About 20-30 patients receive treatment and diabetes education at each session. The clinic has led the way for diabetes treatment at ACMC, and has demonstrated that a multidisciplinary educational and self-management approach to diabetic patients can result in improved control and outcome measures. This has created a foundation for chronic disease management at ACMC using the Chronic Care Model and panel management.

DSRIP Semi-Annual Reporting Form

Category 3: At-Risk Populations (required)

Monthly diabetes support groups are offered in both English and Spanish and provide diabetic patients with a comfortable and safe place to talk about their experiences and issues living with diabetes. These support groups are not meant to be educational classes, and are largely designed by the group at the first meeting. A diabetes educator is present for all meetings to assist with necessary information but not to be an active participant or leader.

The panel management program, with the data provided by i2i Tracks, our disease management registry (see report on Disease Management Registry for more details) is a primary strategy for diabetes care improvement. For LDL improvement the panel management coordinators do "in-reach" (in-reach is part of the panel management program in which care gaps are identified for patients who are coming in for an appointment and if appropriate, addressed by the medical provider). For instance, they will highlight the LDL value if it is >100 so the provider will see to make an intervention. They also do outreach—e.g., calling patients to get the lab done before their appointment. Patient visit summaries printed from i2i Tracks highlight a patient's LDL-C and HbA1c level and history as well as other important factors. Panel management coordinators actively monitor all diabetes cases and prompt physicians when tests or other interventions are due.

In addition, we are developing basic standing orders for mammography, diabetes, and vaccinations; these will be instituted in the next year.

Achievement

Yes

Achievement Value

1.00

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

Data Collection Source

* Data warehouse

Numerator

* 2,251.0

Denominator

* 5,368.0

Rate

41.93

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

ACMC is reporting that 41.93% of patients age 18-75 years with diabetes who have visited ACMC primary care clinics two or more times in FY 10/11 had their most recent HbA1c level in control [<8%] in FY 11/12 (DY7).

Method:

A team that included the Medical Director of Ambulatory Care, the Chief Medical Information Officer, the Clinical Data Coordinator and our Health Information System (HIS) consultant met over several months to review the measures and to determine the most effective means to report the data. Trial reports were generated and were reviewed by the group. Further testing and refinements of the report were made until the group was satisfied that we had the most accurate report possible.

ACMC is currently transitioning to an electronic health record, but until the EHR is in place, we rely on multiple systems for reporting data. In addition to the HIS, ACMC uses i2i Tracks, a population health management system that aggregates data from different sources and generates disease registry reports.

Denominator: The list of patients that qualify was obtained from the HIS.

Numerator: The list of patients who received an HbA1c test during the demonstration year was obtained from i2i Tracks. This report was cross-referenced with the list of eligible patients to obtain the number of patients who are in compliance.

Related program improvement efforts:

ACMC has a weekly diabetes specialty clinic for newly diagnosed patients as well as those whose disease is not well-controlled. About 20-30 patients receive treatment and diabetes education at each session. The clinic has led the way for diabetes treatment at ACMC, and has demonstrated that a multidisciplinary educational and self-management approach to diabetic patients can result in improved control and outcome measures. This has created a foundation for chronic disease management at ACMC using the Chronic Care Model and panel management.

DSRIP Semi-Annual Reporting Form

Category 3: At-Risk Populations (required)

For A1c process improvement, we use the same tools as those described in the LDL report—panel management coordinators use i2i Tracks to work with the clinical team and patients to improve disease management. In addition, we have developed ambulatory and inpatient clinical pharmacy programs that support the improvement activities for diabetes patients.

In the ambulatory setting, a clinical pharmacist program has been established. A dedicated pharmacist does medication management in the primary care setting by appointment and telephone, and works closely with primary care providers to help patients get their diabetes under control. A protocol was written and approved for a clinical pharmacist to manage medications for diabetes, hypertension, and hyperlipidemia, and it is used in primary care as well as the diabetes clinic.

In the inpatient setting, a pilot was conducted in April and May of 2012 of a transitional care pharmacist. This is an example of ACMC using a PDSA learning cycle. Compared to the control group (usual care), patients receiving care from the transitional care pharmacist had fewer readmissions at 30-days post-discharge, and improved post-discharge follow-up attendance. Based on this pilot, funding for a transitional care pharmacist position was approved through the DSRIP Oversight Committee. The pharmacist will teach patients, and their families and caregivers, how to manage their insulin and other medications. This role will be fully integrated with the care transitions program (described in the Care Transitions milestone report).

Finally, we are developing basic standing orders for mammography, diabetes, and vaccinations; these will be instituted in the next year.

Achievement

Yes

Achievement Value

1.00

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
 DPH SYSTEM: Alameda County Medical Center
 REPORTING YEAR: DY 7
 DATE OF SUBMISSION: 9/29/2012

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:	* \$ 1,875,500.00
Incentive Funding Already Received in DY:	* \$ 937,750.00
Compliance with Sepsis Resuscitation bundle (%)	
Numerator	* 82
Denominator	* 228
% Compliance	0.36
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):	
<div style="border: 1px solid black; padding: 5px;"> Numerator = # compliant with sepsis resuscitation bundle; denominator = # Severe Sepsis The rate of compliance to the full sepsis resuscitation bundle for DY7 (July 2011 through June 2012), as reported to the Integrated Nurse Leadership Program (INLP), was 36%. In-depth description of milestone progress is included in the following box. </div>	
DY Target (from the DPH system plan, if appropriate)	*
% Achievement of Target	N/A
<i>Achievement Value</i>	1.00
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 <div style="text-align: center; margin-left: 150px;"><i>(insert milestone)</i></div>	
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:	
<div style="border: 1px solid black; padding: 5px;"> The second half of DY7 was a challenging time for our quality program, yet it was also a time of significant changes that we anticipate will enable us to reach the target improvements in sepsis mortality and bundle compliance for this year and the future. During this period, under the leadership of our new Vice President of Quality, who began in August 2011, there was a significant reorganization of the Quality Department. A combination of retirements and pre-existing vacancies had resulted in an under-staffed department. This presented the opportunity to re-build the department, transforming it from an old-school quality assurance department to a performance improvement system, better able to support ACMC in achieving a new level of quality as we enter into a new era under health care reform. In April of 2012, two new leaders were hired, the Director of Quality and Performance Improvement and the Director of Accreditation, Risk Management and Patient Safety. An epidemiologist with a higher level of training and experience than previous staff joined the team in May as a quality analyst. </div>	
* Yes	

DSRIP Semi-Annual Reporting Form

Category 4: Severe Sepsis Detection and Management (required)

Through the guidance and support of the Integrated Nurse Leadership Program, funded by the Gordon and Betty Moore foundation in 2010, a comprehensive, evidence-based approach to sepsis screening and delivery of Early Goal Directed Therapy (EGDT) was developed; ACMC met and exceeded the goal, which was to decrease sepsis mortality by 15% over 2 years. The effort involved a group of core clinical nursing staff and several physician champions embedding a hospital-wide approach to sepsis screening and creating an order set for EGDT. It also included ongoing data collection with monthly reports to monitor and revise processes as necessary.

During the period from July 2010 through December 2011, hospital-wide education was initiated, and a video, "Sepsis: The Highland Way," was created to provide an innovative educational experience to all staff. This unique video included staff from throughout the organization, thereby increasing "ownership" of the project. It has had over 26,000 hits on YouTube. This initiative is currently ongoing, with a goal of maintaining low sepsis mortality rates and to decrease mortality by an additional 5% over the 2013 fiscal year. The Sepsis Team presented, by invitation, at the BEACON Multidisciplinary Collaborative Meeting on April 17, 2012, on the topic of ACMC Sepsis Improvements.

The interdisciplinary Sepsis harm reduction team met regularly through 2011; there was a period of irregular meetings in the beginning of 2012 due to staff turnover. As of June 2012 the sepsis team has regained momentum with new members as well as continuing members, all of whom are committed to reducing sepsis mortality.

The team has been working with quality department analysts to improve the accuracy and availability of sepsis mortality data, ICD-9 coded data, non ICD-9 coded data, and bundle compliance data. These data are now collected and reported monthly at a Critical Care Committee Meeting.

The sepsis team has had consistent engagement by a physician champion and members of the nursing staff. The team's monthly meetings are attended by a wide range of stake-holders from Quality, ICU, ED, Nursing, Pharmacy, Internal Medicine, and Critical Care and this interdisciplinary participation has helped us to improve communication between departments. The involvement of front line clinicians and a systematic approach has supported the timely delivery of antibiotics and fluids as well as the obtaining of lactic acids. Through monthly data collection, the group was able to recognize areas for improvement, such as lactate as a critical value, POC lactate testing, and the Rapid Response Nurse responding to all "positive" screens in the medical-surgical areas. Sepsis screenings are now completed on all inpatients at 8:00, 16:00 and 24:00. If a "positive" screen is noted, a lactic acid is drawn, and on the medical surgical floors, Rapid Response is notified.

The "Sepsis: the Highland Way" video is utilized as a teaching tool for new hires and for annual competencies. All newly hired nurses receive education on sepsis and sepsis screening, as well as annual reviews of sepsis competencies. The harm reduction team will work to set up a system to ensure re-education efforts continue for all relevant staff to maintain a high level of compliance and understanding.

ACMC uses Smart Orders, a web-based tool that creates admission checklists (order sets); sepsis bundle order sets have been created in Smart Orders in order to help reinforce compliance with both the 6 hour and 24 hour bundles. Recognizing the upcoming transfer to the Electronic Health Record system, the sepsis team has been working to ensure sepsis order sets will be included in the new EHR.

A project assistant and a critical care outcomes analyst nurse were hired in May 2012 in order to improve the efficiency and productivity of the sepsis team. These two positions are indicative of ACMC's growing commitment to improving reporting, reducing sepsis mortality, and increasing bundle compliance. These positions support the sustainability of current projects and implementation of further initiatives. An additional role has been identified and piloted, a sepsis nurse who will work to improve bundle compliance and educate on other sepsis-related efforts. We anticipate that this position will be filled in the first half of DY8.

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

*

Achievement Value

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

[If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:](#)

*

Numerator = # compliant with sepsis resuscitation bundle; denominator = # Severe Sepsis
ACMC Baseline (CY2011) is 34%.

ACMC reported 12 months of Sepsis Resuscitation Bundle Compliance data to SNI on June 26, 2012. Our baseline data is from Calendar Year 2011 (1/1/2011 - 12/31/2011) as it was reported to the Integrated Nurse Leadership Program (INLP).

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

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

*

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
 DPH SYSTEM: Alameda County Medical Center
 REPORTING YEAR: DY 7
 DATE OF SUBMISSION: 9/29/2012

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

Below is the data reported for the DPH system.

* *Instructions for DPH systems: Please type in all of your DY milestones for the project below and report data in the indicated boxes (*).*

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

Central Line Associated Blood Stream Infection													
DY Total Computable Incentive Amount:	* \$ 1,875,500.00												
Incentive Funding Already Received in DY:	* \$ 1,641,062.50												
Compliance with Central Line Insertion Practices (CLIP) (%)													
Numerator	* 225.00												
Denominator	* 228.00												
% Compliance	0.99												
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):													
<div style="border: 1px solid black; padding: 5px;"> <p>The baseline rate for completeness of CLIP forms was 99.14% for CY 2010, as reported to NHSN. DY7 saw a 98.68% rate for completeness of CLIP forms, 225/228 forms completed.</p> <p>Numerator = # completed CLIP Forms; denominator = total # CLIP Forms Data as reported to NHSN website - Reporting period 7/1/2011 to 6/30/2012</p> <p>In-depth description of milestone progress is included in the following box.</p> </div>													
DY Target (from the DPH system plan)	* 												
% Achievement of Target	N/A												
<i>Achievement Value</i>	1.00												
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; vertical-align: top; padding: 5px;">Optional Milestone:</td> <td style="padding: 5px;"> 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 <div style="text-align: center; font-size: small; margin-top: 5px;">(insert milestone)</div> </td> </tr> <tr> <td style="padding: 5px;">Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)</td> <td style="text-align: right; padding: 5px;">* </td> </tr> <tr> <td style="padding: 5px;">Denominator (if absolute number, enter "1")</td> <td style="text-align: right; padding: 5px;">* </td> </tr> <tr> <td style="padding: 5px;">Achievement</td> <td style="text-align: right; padding: 5px;">Yes</td> </tr> <tr> <td colspan="2" style="padding: 5px;"> If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions: </td> </tr> <tr> <td colspan="2" style="padding: 5px;">* Yes</td> </tr> </table>		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 <div style="text-align: center; font-size: small; margin-top: 5px;">(insert milestone)</div>	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	
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 <div style="text-align: center; font-size: small; margin-top: 5px;">(insert milestone)</div>												
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													
<div style="border: 1px solid black; padding: 5px;"> <p>The second half of DY7 was a challenging time for our quality program, yet it was also a time of significant changes that we anticipate will enable us to reach the target improvements in CLABSI for this year and the future.</p> <p>During this period, under the leadership of our new Vice President of Quality, who began in August 2011, there was a significant reorganization of the Quality Department. A combination of retirements and pre-existing vacancies had resulted in an under-staffed department. This presented the opportunity to re-build the department, transforming it from an old-school quality assurance department to a performance improvement system, better able to support ACMC in achieving a new level of quality as we enter into a new era under health care reform.</p> <p>In April of 2012, two new leaders were hired, the Director of Quality and Performance Improvement and the Director of Accreditation, Risk Management and Patient Safety. An epidemiologist with a higher level of training and experience than previous staff joined the team in May as a quality analyst.</p> <p>CLABSI improvement efforts were originally part of the ICU Systems committee, which met regularly through 2011. In May of 2012, the CLABSI team began meeting separately on a monthly basis. They report periodically to the Critical Care Committee as well as the Quality Council. Membership includes nurses, physicians, quality analysts, and members of the Infection Control Department.</p> </div>													

DSRIP Semi-Annual Reporting Form

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

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

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

Some of the education and improvement activities that are supported by this expanded team include:

- In order to increase the use of CLIP forms for all central line patients, the CLIP form has been attached to all line kits. The frequency of cart restocking has increased, and monthly audits of IV tubing maintenance have begun.
- Through role-modeling by attending physicians in the ICU, junior medical staff has been fully engaged in the completion of CLIP forms and adoption of the CLIP standards in the medical center. This role-modeling contributes to sustaining and embedding CLIP.
- In June, a targeted re-education program for inpatient nurses was piloted through in-service education to inpatient nurses regarding care of central lines. An open invitation for people to attend a class on dec clotting procedure was sent to all inpatient nursing staff and based on positive feedback, the class will be repeated.

By using data, we engage staff in best practices to maintain low CLABSI rates. We regularly present CLABSI rates to staff using graphs and tables on notice and bulletin boards, while also reinforcing good practice and outlining opportunities for improvement. Quality analysts are working to create a more efficient and transparent monthly hospital report on CLABSI as well. The barriers that the CLABSI harm reduction team has faced are largely related to staff and physician support. We have had a strong physician champion for CLABSI and Sepsis, but she has taken on other responsibilities, so we are seeking a new physician champion. We are continuing to examine and test how staff roles can best be organized to support best practices regarding central lines.

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

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

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

*

Achievement Value

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 provide an in-depth description of progress towards milestone achievement as stated in the instructions:](#)

*

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

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

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

*

Achievement Value

DSRIP Semi-Annual Reporting Form

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

<p>Optional Milestone: Report at least 6 months of data collection on CLABSI to SNI for purposes of establishing the baseline and setting benchmarks. <small>(insert milestone)</small></p>	
Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	* <input type="text" value="14.00"/>
Denominator (if absolute number, enter "1")	* <input type="text" value="10,427.00"/>
Achievement	<input type="text" value="0.00134"/>
<p>If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:</p>	
<div style="border: 1px solid black; padding: 5px;"> <p>ACMC CLABSI Rate Baseline (CY2010) is 1.34 (Rate = (CLABSI Events/Central Line Days)*1000) ACMC expanded our baseline from 6 to 12 months and reported 12 months of CLABSI data to SNI on June 26, 2012. Our baseline data is from Calendar Year 2010 (1/1/2010 - 12/31/2010) as it was reported to National Healthcare Safety Network (NHSN).</p> <p>In-depth description of milestone progress is included in the previous box.</p> </div>	
DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	* <input type="text" value="yes"/>
<i>Achievement Value</i>	<input type="text" value="1.00"/>

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
 DPH SYSTEM: Alameda County Medical Center
 REPORTING YEAR: DY 7
 DATE OF SUBMISSION: 3/22/2013

Category 4: Surgical Site Infection Prevention

REPORTING ON THIS PROJECT: *

Below is the data reported for the DPH system.

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

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

Surgical Site Infection Prevention	
DY Total Computable Incentive Amount:	* \$ 1,875,500.00
Incentive Funding Already Received in DY:	* \$ 1,875,500.00
Rate of surgical site infection for Class 1 and 2 wounds (%)	
Numerator	* <input style="border: 1px solid black; width: 80px; text-align: center;" type="text" value="14.00"/>
Denominator	* <input style="border: 1px solid black; width: 80px; text-align: center;" type="text" value="250.00"/>
% Infection Rate	<input style="border: 1px solid black; width: 80px; text-align: center;" type="text" value="0.056"/>
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):	
<p>ACMC is making a correction to the SSI data for FY11/12, based on review and validation of the data.</p> <p>In recent months, the Quality and Infection Control departments have reviewed and improved internal data management processes in order to improve timeliness and accuracy of reporting. As a result of this process of validation of SSI data, we are reporting small changes to the numerator and denominator and the infection rate.</p> <p>Our corrected SSI data for each procedure is as follows: Joints: $(1/115) \times 100 = 0.87$ [Knees = 1/61; Hips = 0/54] Colons: $(11/51) \times 100 = 21.57$ Hysterectomies: $(2/84) \times 100 = 2.38$</p> <hr style="width: 25%; margin-left: 0;"/> <p>ACMC has chosen knee and hip arthroplasties (Joints), colon resections, and hysterectomies as the three procedures to target for improvement. Our SSI data for each procedure is as follows: Joints: $(1/118) \times 100 = 0.85$ [Knees = 1/61; Hips = 0/57] Colons: $(10/45) \times 100 = 22.22$ Hysterectomies: $(2/79) \times 100 = 2.53$</p> <p>The second half of DY7 was a challenging time for our quality program, yet it was also a time of significant changes that we anticipate will enable us to reach the target improvements in SSI for this year and the future.</p> <p>During this period, under the leadership of our new Vice President of Quality, who began in August 2011, there was a significant reorganization of the Quality Department. A combination of retirements and pre-existing vacancies had resulted in an under-staffed department. This presented the opportunity to re-build the department, transforming it from an old-school quality assurance department to a performance improvement system, better able to support ACMC in achieving a new level of quality as we enter into a new era under health care reform.</p> <p>In April of 2012, two new leaders were hired, the Director of Quality and Performance Improvement and the Director of Accreditation, Risk Management and Patient Safety. An epidemiologist with a higher level of training and experience than previous staff joined the team in May as a quality analyst.</p>	

DSRIP Semi-Annual Reporting Form

Category 4: Surgical Site Infection Prevention

However, the Director of Infection Control recently retired and we are still actively recruiting for that position. The Performance Improvement Director participated in the Joint Commission SSI Collaborative and brings this expertise to ACMC.

One of the activities of the new Quality team has been to re-establish harm reduction teams, setting new SMART objectives for phase II, such as developing and implementing a wound management protocol for nursing to use with post-operative patients.

Staff turnover and recruiting have been major barriers for the reduction of Surgical Site Infections, but, thanks to the hard work and dedication of our infection control team and quality department, this has not prevented us from meeting our milestones in DY7.

Two new surgeons have been recruited and will be starting in DY8. One of these has a background in Quality Improvement, and the Chair of Surgery will be assigning her to work with the SSI team as physician champion. The acquisition of Surgical Site Infection data is a time and resource-intensive process due to the need for chart reviews and data validation. We have faced some challenges related to coding and wound classification that have resulted in delays in identification of "true" surgical site infections. To help with this process, a position for a dedicated quality analyst to support NHSN reporting was identified to start in FY2012-13. The Infection Control department continues to collaborate with surgeons in order to standardize the processes related to coding and wound classification. This dedicated quality analyst will support this effort to standardize coding.

Finally, the nursing education program is in the planning stages for implementation of a two-part education program: for patients, education on SSI prevention through written materials and a video presentation; and for healthcare providers, an education program that will incorporate an SSI prevention component into the e-learning program that is already in place for ACMC staff.

DY Target (from the DPH system plan)

*

% Achievement of Target

Achievement Value

DSRIP Semi-Annual Reporting Form

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 APMC 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 provide an in-depth description of progress towards milestone achievement as stated in the instructions:](#)

*

ACMC is clarifying the number of procedures reported for SSI.

In the September 2012 DSRIP report (and all prior reports), we counted knee and hip arthroplasties (Joints) as one procedure. We reported these as a total of three procedures altogether (joints, colons and hysterectomies). However, we have realized that, as defined by the NHSN Operative Procedures identified by CDPH, knee and hip arthroplasties are two separate procedures. Therefore we are actually reporting on **four** procedures.

The reason we proposed Joints (HPRO+KPRO) is that the combination of two NHSN categories gives us a robust denominator to work with and reflects a problem that causes significant morbidity for patients. The long term effect of a joint replacement infection is life-changing for patients. In addition, the process of care for HPRO and KPRO is very similar. We chose the three (now four) procedures as we did to represent three distinct surgical groups and to align DSRIP with surgeries being used by CMS for the pay for performance mandate. The explanation of data to the hospital community needs to be simple and consistent to support credibility of Quality efforts.

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ACMC has chosen knee and hip arthroplasties (Joints), colon resections, and hysterectomies as the three procedures to target for improvement.

On June 26th, 2012, we reported baseline data to SNI for all of our top three procedures causing SSI.

We reported 12 months of baseline data for Joints (knee and hip arthroplasties) from CY2010 (1/1/2010-12/31/2010) as follows:  
 (2 SSI/58 knee& hip arthroplasties)\*100 = 3.45

We reported 12 months of baseline data for Colons from CY2010 (1/1/2010-12/31/2010) as follows:  
 (7 SSI/18 Colon Resections)\*100=38.89

We reported 6 months of baseline data for hysterectomies from 7/1/2011 - 12/31/2011 (this is the first data we have in this category) as follows:  
 (1 SSI/38 Hysterectomies)\*100=2.63

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

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

\*

*Achievement Value*

**DSRIP Semi-Annual Reporting Form**

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)  
 DPH SYSTEM: Alameda County Medical Center  
 REPORTING YEAR: DY 7  
 DATE OF SUBMISSION: 9/29/2012

**Category 4: Hospital-Acquired Pressure Ulcer Prevention**

REPORTING ON THIS PROJECT: \*

Below is the data reported for the DPH system.

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

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

**Hospital-Acquired Pressure Ulcer Prevention**

DY Total Computable Incentive Amount: \*

Incentive Funding Already Received in DY: \*

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

Numerator \*

Denominator \*

Prevalence (%)

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

Data as reported to CALNOC Website - Reporting Period: 7/1/2011 - 6/30/2012  
 8 patients had stage II, III, IV, or unstagable pressure ulcers. 402 patients were surveyed.

ACMC has participated in the CalNOC pressure ulcer prevalence survey since January 16, 2007. Initially we held partial membership, and became a full member on December 23, 2011. We conduct the pressure ulcer prevalence survey quarterly at Highland Campus, ACMC's acute care hospital. For DY7, occurrences of stage II, III, IV and unstageables were as follows:  
 Jul-Sep 2011: 4/101  
 Oct-Dec 2011: 2/93  
 Jan-Mar 2012: 1/112  
 Apr-Jun 2012: 1/96

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

DY Target (from the DPH system plan) \*

% Achievement of Target

*Achievement Value*

## DSRIP Semi-Annual Reporting Form

### 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

If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:

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

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

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

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

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

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

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

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

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

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

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

*Achievement Value*

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