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

Reporting Form Instructions

Dates Reports are Due

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

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

Use of This Reporting Form

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

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

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

In the narrative summary box for each milestone, DPHs must include an assessment of overall project implementation, including brief but detailed narrative descriptions of:

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

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

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

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

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

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

* **DPH SYSTEM:**	Arrowhead Regional Medical Center
* **REPORTING YEAR:**	DY 7
* **DATE OF SUBMISSION:**	9/30/2012

Total Payment Amount

This table sums the eligible incentive funding amounts. Please see the following pages for the specifics.
* Instructions for DPH systems: Please input the DPH System Name, Reporting DY & Date. Everything else on this tab will automatically populate.

Category 1 Projects - Incentive Funding Amounts	
Expand Primary Care Capacity	$ 2,777,820.50
Increase Training of Primary Care Workforce	$ 1,851,880.33
Implement and Utilize Disease Management Registry Functionality	$ 3,125,047.50
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	$ 2,500,038.45
Enhance Performance Improvement and Reporting Capacity	
TOTAL CATEGORY 1 INCENTIVE PAYMENT:	$ 10,254,786.78
Category 2 Projects	
Expand Medical Homes	$ 4,297,769.44
Expand Chronic Care Management Models	$ 5,348,335.30
Redesign Primary Care	$ 2,546,826.34
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:	$ 12,192,931.08
Category 3 Domains	
Patient/Care Giver Experience *(required)*	$ -
Care Coordination *(required)*	$ 1,930,500.00
Preventive Health *(required)*	$ 1,930,500.00
At-Risk Populations *(required)*	$ 1,930,500.00
TOTAL CATEGORY 3 INCENTIVE PAYMENT:	$ 5,791,500.00
Category 4 Interventions	
Severe Sepsis Detection and Management *(required)*	$ 68,062.50

Central Line Associated Blood Stream Infection Prevention *(required)*	$ (72,600.00)
Surgical Site Infection Prevention	
Hospital-Acquired Pressure Ulcer Prevention	$ 287,375.00
Stroke Management	$ -
Venous Thromboembolism (VTE) Prevention and Treatment	
Falls with Injury Prevention	
TOTAL CATEGORY 4 INCENTIVE PAYMENT:	$ 282,837.50
TOTAL INCENTIVE PAYMENT	$ 28,522,055.36

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/30/2012

Annual Report Narrative

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

Summary of Demonstration Year Activities

Summary of DPH System's Participation in Shared Learning

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/30/2012

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:	(5) Hire 2 additional primary care providers and staff	Yes
Achievement Value		*1.00*
Process Milestone:	(6) Expand existing primary care locations by at least one (MOB)	Yes
Achievement Value		*1.00*
Process Milestone:		N/A
Achievement Value		
Process Milestone:		N/A
Achievement Value		
Process Milestone:		N/A
Achievement Value		
Improvement Milestone:	(4) Increase ARMC FHC primary care clinic volume by 2% over baseline	Yes
Achievement Value		*1.00*
Improvement Milestone:		N/A
Achievement Value		
Improvement Milestone:		N/A
Achievement Value		
Improvement Milestone:		N/A
Achievement Value		
Improvement Milestone:		N/A
Achievement Value		
DY Total Computable Incentive Amount:		$ 5,555,641.00
Total Sum of Achievement Values:		3.00
Total Number of Milestones:		3.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 5,555,641.00
Incentive Funding Already Received in DY:		$ 2,777,820.50
Incentive Payment Amount:		$ 2,777,820.50

Category 1 Summary Page

Increase Training of Primary Care Workforce

Process Milestone:	(15) Expand primary care training by hiring one additional precepting primary care	Yes
Achievement Value		*1.00*
Process Milestone:	(16) Expand positive primary care exposure for residents (train in medical home	Yes
Achievement Value		*1.00*
Process Milestone:		N/A
Achievement Value		
Process Milestone:		N/A
Achievement Value		
Process Milestone:		N/A
Achievement Value		
Improvement Milestone:	(14) Increase primary care training by recruiting for at least 2 additional primary	Yes
Achievement Value		*1.00*
Improvement Milestone:		N/A
Achievement Value		
Improvement Milestone:		N/A
Achievement Value		
Improvement Milestone:		N/A
Achievement Value		
Improvement Milestone:		N/A
Achievement Value		
DY Total Computable Incentive Amount:		$ 5,555,641.00
Total Sum of Achievement Values:		3.00
Total Number of Milestones:		3.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 5,555,641.00
Incentive Funding Already Received in DY:		$ 3,703,760.67
Incentive Payment Amount:		$ 1,851,880.33

Category 1 Summary Page

Implement and Utilize Disease Management Registry Functionality

Process Milestone:	(21) Re-implement a functional disease registry (diabetes) at one of ARMC's	Yes
Achievement Value		*1.00*
Process Milestone:	(22) Conduct training to at least 25% of ARMC FHC staff on populating and using	Yes
Achievement Value		*1.00*
Process Milestone:	(23) Demonstrate registry automated reporting ability to track and report on patient	Yes
Achievement Value		*1.00*
Process Milestone:		N/A
Achievement Value		
Process Milestone:		N/A
Achievement Value		
Improvement Milestone:	(24) Enter at least 400 diabetic patients into the registry	Yes
Achievement Value		*1.00*
Improvement Milestone:		N/A
Achievement Value		
Improvement Milestone:		N/A
Achievement Value		
Improvement Milestone:		N/A
Achievement Value		
Improvement Milestone:		N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ 5,555,640.00
Total Sum of Achievement Values:	4.00
Total Number of Milestones:	4.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 5,555,640.00
Incentive Funding Already Received in DY:	$ 2,430,592.50
Incentive Payment Amount:	$ 3,125,047.50

Category 1 Summary Page

Category 1 Summary Page

Category 1 Summary Page

Category 1 Summary Page

Category 1 Summary Page

Category 1 Summary Page

Category 1 Summary Page

Expand Specialty Care Capacity

Process Milestone:	(38) Collect baseline for number of days to process referrals and wait time from	Yes
Achievement Value		*1.00*
Process Milestone:	(39) Expand the ambulatory care medical specialties referral management	Yes
Achievement Value		*1.00*
Process Milestone:	(40) Establish specialty care guidelines for the high/most impacted medical	Yes
Achievement Value		*1.00*
Process Milestone:	(41) Train 15% of primary care providers, specialists and staff on processes,	Yes
Achievement Value		*1.00*
Process Milestone:	(42) Provide reports on number of days to process referrals, and wait time from	Yes
Achievement Value		*1.00*
Improvement Milestone:		N/A
Achievement Value		
Improvement Milestone:		N/A
Achievement Value		
Improvement Milestone:		N/A
Achievement Value		
Improvement Milestone:		N/A
Achievement Value		
Improvement Milestone:		N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ 5,555,641.00
Total Sum of Achievement Values:	5.00
Total Number of Milestones:	5.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 5,555,641.00
Incentive Funding Already Received in DY:	$ 3,055,602.55
Incentive Payment Amount:	$ 2,500,038.45

Category 1 Summary Page

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/30/2012

Category 2 Summary Page

This table is the summary of data reported for the DPH system. Please see the following pages for the specifics.
* *Instructions for DPH systems: Do not complete, this tab will automatically populate.*
The black boxes indicate Milestone achievements, either "yes/no", or the actual achievement # or %.
The blue boxes show progress made toward the Milestone ("Achievement Value") of 1.0, 0.75. 0.5, 0.25 or 0.
The red boxes indicate Total Sums.

Category 2 Projects

Expand Medical Homes

Process Milestone:	(49) Put in place policies and systems to enhance patient access to the medical	Yes
Achievement Value		*1.00*
Process Milestone:	(50) Reorganize staff into primary care teams responsible for the coordination of	Yes
Achievement Value		*1.00*
Process Milestone:	(51) Establish criteria for medical home assignment	Yes
Achievement Value		*1.00*
Process Milestone:	(52) Develop training materials for medical homes	Yes
Achievement Value		*1.00*
Process Milestone:	(53) Designate/hire Panel Managers to support and oversee panel management at	Yes
Achievement Value		*1.00*
Process Milestone:	(54) Train at least 25% of ARMC FHC staff on the medical home model	Yes
Achievement Value		*1.00*
Process Milestone:	(55) Implement the medical home model at one ARMC FHC (pilot)	Yes
Achievement Value		*1.00*
Improvement Milestone:	(56) At least 50% of new patients assigned to the pilot medical home receive their	Yes
Achievement Value		*1.00*
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ 7,640,479.00
Total Sum of Achievement Values:	8.00
Total Number of Milestones:	8.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 7,640,479.00
Incentive Funding Already Received in DY:	$ 3,342,709.56
Incentive Payment Amount:	$ 4,297,769.44

Category 2 Summary Page

Expand Chronic Care Management Models

Process Milestone:	(64) Implement the Chronic Care Model for diabetes at one ARMC FHC (pilot)	0.50
Achievement Value		*0.50*
Process Milestone:	(66) Train at least 25% of staff in the Care Model	Yes
Achievement Value		*1.00*
Process Milestone:	(67) Formalize multi-disciplinary teams in one ARMC FHC	Yes
Achievement Value		*1.00*
Process Milestone:	(68) Designate/hire a chronic disease case manager to provide case management	Yes
Achievement Value		*1.00*
Process Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	(65) Apply the Chronic Care Model to one targeted chronic disease (diabetes)	Yes
Achievement Value		*1.00*
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ 7,640,479.00
Total Sum of Achievement Values:	4.50
Total Number of Milestones:	5.00
Achievement Value Percentage:	90%
Eligible Incentive Funding Amount:	$ 6,876,431.10
Incentive Funding Already Received in DY:	$ 1,528,095.80
Incentive Payment Amount:	$ 5,348,335.30

Category 2 Summary Page

Redesign Primary Care

Process Milestone:	(79) Implement a practice management system	Yes
Achievement Value		*1.00*
Process Milestone:	(80) Implement patient visit redesign at one ARMC FHC (pilot)	0.75
Achievement Value		*0.75*
Process Milestone:	(81) Train 25% of ARMC FHC staff on methods for redesigning clinics to improve	0.25
Achievement Value		*0.25*
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		

DY Total Computable Incentive Amount:	$ 7,640,479.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	3.00
Achievement Value Percentage:	67%
Eligible Incentive Funding Amount:	$ 5,093,652.67
Incentive Funding Already Received in DY:	$ 2,546,826.33
Incentive Payment Amount:	$ 2,546,826.34

Category 2 Summary Page

Redesign to Improve Patient Experience

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

Category 2 Summary Page

Redesign for Cost Containment

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

Category 2 Summary Page

Integrate Physical and Behavioral Health Care

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

Category 2 Summary Page

Increase Specialty Care Access/Redesign Referral Process

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

Category 2 Summary Page

Establish/Expand a Patient Care Navigation Program

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

Category 2 Summary Page

Apply Process Improvement Methodology to Improve Quality/Efficiency

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

Category 2 Summary Page

Improve Patient Flow in the Emergency Department/Rapid Medical Evaluation

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

Category 2 Summary Page

Use Palliative Care Programs

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

Category 2 Summary Page

Conduct Medication Management

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

Category 2 Summary Page

Implement/Expand Care Transitions Programs

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

Category 2 Summary Page

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

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

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/30/2012

Category 3 Summary Page

This table is the summary of data reported for the DPH system. Please see the following pages for the specifics.
* *Instructions for DPH systems: Do not complete, this tab will automatically populate.*
The black boxes indicate Milestone achievements, either "yes/no", or the actual achievement # or %.
The blue boxes show progress made toward the Milestone ("Achievement Value") of 1.0, 0.75. 0.5, 0.25 or 0.
The red boxes indicate Total Sums.

Category 3 Domains	
Patient/Care Giver Experience (required)	
Undertake the necessary planning, redesign, translation, training and contrac negotiations in order to implement CG-CAHPS in DY8 (DY7 only)	Yes
Achievement Value	1.00
Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme to the State (DY8-10)	N/A
Achievement Value	
Report results of CG CAHPS questions for "How Well Doctors Communicate With Patients" theme to the State (DY8-10)	N/A
Achievement Value	
Report results of CG CAHPS questions for "Helpful, Courteous, and Respectful Office Staff" theme to the State (DY8-10)	N/A
Achievement Value	
Report results of CG CAHPS questions for "Patients' Rating of the Doctor" theme to the State (DY8-10)	N/A
Achievement Value	
Report results of CG CAHPS questions for "Shared Decisionmaking" theme to the State (DY8-10)	N/A
Achievement Value	
DY Total Computable Incentive Amount:	$ 3,861,000.00
Total Sum of Achievement Values:	1.00
Total Number of Milestones:	1.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 3,861,000.00
Incentive Funding Already Received in DY:	$ 3,861,000.00
Incentive Payment Amount:	$ -

Category 3 Summary Page

Care Coordination (required)

Report results of the Diabetes, short-term complications measure to the State (DY7-10)	Yes
Achievement Value	1.00
Report results of the Uncontrolled Diabetes measure to the State (DY7-10)	Yes
Achievement Value	1.00
Report results of the Congestive Heart Failure measure to the State (DY8-10)	N/A
Achievement Value	
Report results of the Chronic Obstructive Pulmonary Disease measure to the State (DY8-10)	N/A
Achievement Value	
DY Total Computable Incentive Amount:	$ 3,861,000.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	2.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 3,861,000.00
Incentive Funding Already Received in DY:	$ 1,930,500.00
Incentive Payment Amount:	$ 1,930,500.00

Preventive Health (required)

Report results of the Mammography Screening for Breast Cancer measure to the State (DY7-10)	Yes
Achievement Value	1.00
Reports results of the Influenza Immunization measure to the State (DY7-10)	Yes
Achievement Value	*1.00*
Report results of the Child Weight Screening measure to the State (DY8-10)	N/A
Achievement Value	
Report results of the Pediatrics Body Mass Index (BMI) measure to the State (DY8-10)	N/A
Achievement Value	
Report results of the Tobacco Cessation measure to the State (DY8-10)	N/A
Achievement Value	
DY Total Computable Incentive Amount:	$ 3,861,000.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	2.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 3,861,000.00
Incentive Funding Already Received in DY:	$ 1,930,500.00
Incentive Payment Amount:	$ 1,930,500.00

Category 3 Summary Page

At-Risk Populations (required)

Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State (DY7-10)	Yes
Achievement Value	1.00
Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<8%) measure to the State (DY7-10)	Yes
Achievement Value	*1.00*
Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State (DY8-10)	N/A
Achievement Value	
Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State (DY8-10)	N/A
Achievement Value	
Report results of the Pediatrics Asthma Care measure to the State (DY8-10)	N/A
Achievement Value	
Report results of the Optimal Diabetes Care Composite to the State (DY8-10)	N/A
Achievement Value	
Report results of the Diabetes Composite to the State (DY8-10)	N/A
Achievement Value	
DY Total Computable Incentive Amount:	$ 3,861,000.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	2.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 3,861,000.00
Incentive Funding Already Received in DY:	$ 1,930,500.00
Incentive Payment Amount:	$ 1,930,500.00

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/30/2012

Category 4 Summary Page

This table is the summary of data reported for the DPH system. Please see the following pages for the specifics.
* *Instructions for DPH systems: Do not complete, this tab will automatically populate.*
The black boxes indicate Milestone achievements, either "yes/no", or the actual achievement # or %.
The blue boxes show progress made toward the Milestone ("Achievement Value") of 1.0, 0.75. 0.5, 0.25 or 0.
The red boxes indicate Total Sums.

Category 4 Interventions

Severe Sepsis Detection and Management *(required)*

Compliance with Sepsis Resuscitation bundle (%)		0.45
Achievement Value		*1.00*
Optional Milestone:	2) Hire 2 LVNs to assist with medical record review and data abstraction (shared	Yes
Achievement Value		*1.00*
Optional Milestone:	3) Hire Staff Analyst to perform report writing data collection and analysis (shared	Yes
Achievement Value		*1.00*
Optional Milestone:	4) Join the Surviving Sepsis Campaign to learn and share best practices related to	Yes
Achievement Value		*1.00*
Optional Milestone:	5) Train clinical staff on Sepsis Bundle Element and Protocols, Checklists and	0.50
Achievement Value		*0.50*
Optional Milestone:	6) Develop Intensive Care Unit policies and procedures to support compliance with	Yes
Achievement Value		*1.00*
Optional Milestone:	7) Implement the Sepsis Resuscitation Bundle	Yes
Achievement Value		*1.00*
Optional Milestone:	8) Report at least 6 months of data collection on Sepsis Resuscitation Bundle to	Yes
Achievement Value		*1.00*
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
DY Total Computable Incentive Amount:		$ 2,178,000.00
Total Sum of Achievement Values:		7.50
Total Number of Milestones:		8.00
Achievement Value Percentage:		94%
Eligible Incentive Funding Amount:		$ 2,041,875.00
Incentive Funding Already Received in DY:		$ 1,973,812.50
Incentive Payment Amount:		$ 68,062.50

Category 4 Summary Page

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

Compliance with Central Line Insertion Practices (CLIP) (%)		0.88
Achievement Value		1.00
Optional Milestone:	21) Train clinical staff to document line day during rounds as part of daily goal	0.75
Achievement Value		*0.75*
Optional Milestone:	22) Hire Staff Analyst to perform report writing, data collection and analysis (shared	Yes
Achievement Value		*1.00*
Optional Milestone:	23) Hire 2 LVNs to assist with medical record review and data abstraction (shared	Yes
Achievement Value		*1.00*
Optional Milestone:	24) Train clinical staff on the Central Line Bundle (maintain on-going training	0.50
Achievement Value		*0.50*
Optional Milestone:	25) Obtain a baseline on: (1) compliance with optimal catheter site selection, with	Yes
Achievement Value		*1.00*
Optional Milestone:	26) Implement the Central Line Insertion Practices (CLIP)	Yes
Achievement Value		*1.00*
Optional Milestone:	27) Report at least 6 months of data collection on CLIP to SNI for purposes of	Yes
Achievement Value		*1.00*
Optional Milestone:	28) Report at least 6 months of data collection on CLABSI to SNI for purposes of	Yes
Achievement Value		*1.00*
Optional Milestone:	-	N/A
Achievement Value		
DY Total Computable Incentive Amount:		$ 2,178,000.00
Total Sum of Achievement Values:		8.25
Total Number of Milestones:		9.00
Achievement Value Percentage:		92%
Eligible Incentive Funding Amount:		$ 1,996,500.00
Incentive Funding Already Received in DY:		$ 2,069,100.00
Incentive Payment Amount:		$ (72,600.00)

Category 4 Summary Page

Surgical Site Infection Prevention

Rate of surgical site infection for Class 1 and 2 wounds (%)		N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
DY Total Computable Incentive Amount:		$ -
Total Sum of Achievement Values:		-
Total Number of Milestones:		-
Achievement Value Percentage:		
Eligible Incentive Funding Amount:		
Incentive Funding Already Received in DY:		$ -
Incentive Payment Amount:		

Category 4 Summary Page

Hospital-Acquired Pressure Ulcer Prevention

Prevalence of Stage II, III, IV or unstagable pressure ulcers (%)		0.05
Achievement Value		1.00
Optional Milestone:	42) Train physicians, residents, nursing staff and allied health professionals on the	0.75
Achievement Value		*0.75*
Optional Milestone:	43) Hire Staff Analyst to perform report writing data collection and analysis (shared	Yes
Achievement Value		*1.00*
Optional Milestone:	44) Hire 2 LVNs to assist with medical record review and data abstraction (shared	Yes
Achievement Value		*1.00*
Optional Milestone:	45) Establish pressure ulcer baseline data	Yes
Achievement Value		*1.00*
Optional Milestone:	46) Implement hourly rounding by nursing staff in all adult inpatient units	Yes
Achievement Value		*1.00*
Optional Milestone:	47) Join Cal-Noc to report Pressure Ulcer Incidence and Prevalence	0.75
Achievement Value		*0.75*
Optional Milestone:	48) Share data, promising practices, and findings with SNI to foster shared learning	Yes
Achievement Value		*1.00*
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
DY Total Computable Incentive Amount:		$ 2,178,000.00
Total Sum of Achievement Values:		7.50
Total Number of Milestones:		8.00
Achievement Value Percentage:		94%
Eligible Incentive Funding Amount:		$ 2,041,875.00
Incentive Funding Already Received in DY:		$ 1,754,500.00
Incentive Payment Amount:		$ 287,375.00

Category 4 Summary Page

Stroke Management

Optional Milestone:	61) Hire Staff Analyst to perform report writing data collection and analysis (shared	Yes
Achievement Value		*1.00*
Optional Milestone:	62) Hire 2 LVNs to assist with medical record review and data abstraction (shared	Yes
Achievement Value		*1.00*
Optional Milestone:	63) Report at least 6 months of data collection on the 7 stroke management	Yes
Achievement Value		*1.00*
Optional Milestone:	64) Report the data to the State	Yes
Achievement Value		*1.00*
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
DY Total Computable Incentive Amount:		$ 2,178,000.00
Total Sum of Achievement Values:		4.00
Total Number of Milestones:		4.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 2,178,000.00
Incentive Funding Already Received in DY:		$ 2,178,000.00
Incentive Payment Amount:		$ -

Category 4 Summary Page

Venous Thromboembolism (VTE) Prevention and Treatment

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

Category 4 Summary Page

Falls with Injury Prevention

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

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/30/2012

REPORTING ON THIS PROJECT: * Yes

Category 1: Expand Primary Care Capacity

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

Expand Primary Care Capacity

DY Total Computable Incentive Amount: * $ 5,555,641.00

Incentive Funding Already Received in DY: * $ 2,777,820.50

Process Milestone: (5) Hire 2 additional primary care providers and staff
(insert milestone)

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

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

Achievement: Yes

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

3/31/12 - Effective 7/1/11, the County of San Bernardino Board of Supervisors (BOS) approved an agreement between ARMC and the Arrowhead Family Medical Group, Inc. to increase its total number of primary care physicians by two (see Agreement No. 10-362 A-2). Effective 7/12/11, the County of San Bernardino BOS approved Appointments to medical Staff and/or Clinical Privileges of ARMC to include doctors: Saraj Mowjood, DO and Christine Vo, DO of the Arrowhead Family Medical Group, Inc. (see Board Item No. 10 on 7/12/11) to meet this milestone. In addition, Johnson Gill was promoted to Assistant Hospital Administrator, with responsibility to oversee the ambulatory side of ARMC's DSRIP project, including expanding primary care capacity. The staff to support the additional physicians were hired during the second half of DY 7 and will be reported in the final report.

9/30/12 - As of 6/30/12, ARMC's Ambulatory Department hired 19 Clinic Assistants, 5 LVNs, and 2 Case Managers for the primary care clinics. The hiring of these staff members was critical as it would be futile to hire additional providers without the staff to support them during ARMC's transformation to a new way of patient care, i.e. medical home model, empanelment and disease registry. With the introduction and implementation of the medical home, empanelment and disease registry, clinic staff will take on new job duties that may have been considered foreign in the past. Staff will now be more engaged with their patients, providing a leading role in the overall improvement of the health population.

In addition to registering patients, taking vitals and rooming patients, Clinic Assistants are learning to take on new duties such as reconciling medications, assisting in establishing self-management goals and support, patient education for common clinical conditions and utilizing the Registry to assist nurses and primary care practitioners with population management.

LVNs, which are now known as Panel Managers in ARMC's Family Health Centers (FHC) are obtaining the necessary skills to fulfill their new responsibilities including: identifying population management priorities, collaborating with healthcare teams to implement population management, entering data into and maintaining disease registries, performing patient outreach, facilitating patients' access to care, providing support to Health Education staff regarding patient self-management goals and participating in community meetings. LVNs will serve as panel managers for the pods, addressing requests to change PCPs, monitor sizes of panels and empanelment, quality measures, and teach/supervise Clinic Assistants as well as oversee "outreach" for the panel as a whole.

Registered Nurses provide patient care via nurse visits in clinics as well as phone and email visits. They will be responsible to teach and supervise other members of the team who are providing patient education, medication reconciliation and self-management goal setting and coaching.

The Case Manager oversees many of the clinic day-to-day functions and works with complex patients to set and reach self-management goals.

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

Achievement Value: 1.00

Category 1: Expand Primary Care Capacity

Process Milestone: (6) Expand existing primary care locations by at least one (MOB)
(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

3/31/12 - On 10/5/11, ARMC opened a new primary care clinic in its Medical Office Building. The new clinic has 8 exam rooms, a procedure room, patient education area, blood draw room, conference room, managed care clerk office and doctor's offices in approximately 4,952 square feet. The new clinic can accommodate 3 full time equivalent providers. A copy of the new primary care clinic schedule is on file at ARMC.

9/30/12 – ARMC currently operates this clinic at three half day resident clinics and 4 half day attending clinics. Administration is working with the Clinic Physician Champion to increase the number of providers and provider days at this clinic. It is expected that by the end of October 2012, we will have increased the number of providers and provider days, by one Nurse Practitioner and one additional attending clinic day, thus increasing the number of available appointments for patients.

Since opening this clinic in October 2011, 1,387 new patients have been assigned to the clinic and the providers are seeing an average of 255 patients per month. This new primary care clinic provides a convenience to those patients located in the surrounding areas of the hospital as well as a decrease in the wait time to receive a primary care appointment.

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

Achievement Value 1.00

Process Milestone:
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Process Milestone:
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Category 1: Expand Primary Care Capacity

Process Milestone: _____
(insert milestone)

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

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

Achievement Value

Improvement Milestone: (4) Increase ARMC FHC primary care clinic volume by 2% over baseline
(insert milestone)

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

3/31/12 - As reported in DY 6, ARMC's FHC primary care clinic volume (baseline) was 65,592. Looking at the clinic volume for July 1 - December 31, ARMC is projecting to reach approximately 67,000 clinic visits. Final numbers will be reported at the end of DY 7.

9/30/12 - In our original report we submitted a baseline number of 65,592; which only included physician visits. As we have learned more about the patient centered medical home model and its use of many forms of patient care besides the classic clinic visit, we felt it important to include both physician and nurse visits in our baseline. Therefore our new baseline number is 70,358 (physician and nurse visits). For DY 7 primary care clinic visit volume is reported at 73,623, an increase of 3,265 patient visits or 4.6%. The increase in the number of visits seen in our primary care is due in part to hiring additional primary care physicians as well as the addition of primary care services in ARMC's new Medical Office Building. For DY 8 -10 we will explore other types of visits such as phone visits and group visits which will require a great deal of education and training. Said education and training is being developed as the medical home model evolves within ARMC's Family Health Centers and will be presented to all necessary participants as required.

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

Improvement Milestone: _____
(insert milestone)

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

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

Achievement Value

Category 1: Expand Primary Care Capacity

Improvement Milestone: ______________________

(insert milestone)

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

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

Achievement N/A

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

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

Achievement Value

Improvement Milestone: ______________________

(insert milestone)

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

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

Achievement N/A

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

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

Achievement Value

Improvement Milestone: ______________________

(insert milestone)

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

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

Achievement N/A

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

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

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/30/2012

REPORTING ON THIS PROJECT: * Yes

Category 1: Increase Training of Primary Care Workforce

Below is the data reported for the DPH system.

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

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

Increase Training of Primary Care Workforce

DY Total Computable Incentive Amount: * $ 5,555,641.00

Incentive Funding Already Received in DY: * $ 3,703,760.67

Process Milestone: (15) Expand primary care training by hiring one additional precepting primary care faculty provider member

(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

3/31/12 - Effective 7/1/11, the County of San Bernardino Board of Supervisors approved an agreement between ARMC and the Arrowhead Cardiology Medical Group, Inc. to hire one additional precepting primary care faculty provider member (see Agreement No. 10-359 A-2). On 7/12/11, the County of San Bernardino Board of Supervisors approved "Appointments for Medical Staff and/or Clinical Privileges of Arrowhead Regional Medical Center", to include doctors: Farbod Farmand, DO and Katrina Platt, DO, both who are responsible for providing patient care services as well as serve as a precepting primary care faculty member and oversee resident functions (See Board Item No. 17 from 7/12/11).

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

Achievement Value: 1.00

Category 1: Increase Training of Primary Care Workforce

Process Milestone: (16) Expand positive primary care exposure for residents (train in medical home model, chronic care model, disease registry and panel management)

(insert milestone)

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

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

Achievement: Yes

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

3/31/12 - On 12/21/11, Dr. Ebert presented an Introduction to Medical Homes to both attendings and residents. The training gave an introduction to registries, patient self-management support, team-based care model, data to improve your practice and patient experience. Since 12/31/11, additional training have been (and are being) developed to provide a more in-depth training in regards to medical home model, chronic care model, disease registry and panel management. ARMC's DY 7 Final Report will show evidence of additional training.

9/30/12 – As of 6/30/12, Dr. Raval, ARMC's Family Medicine Residency Director, had implemented a Patient Centered Medical Home (PCMH) curriculum which is a required training series for all Family Medicine Residents. Through this curriculum, residents will understand the comprehensive concepts of PCMH as described in the McKee Medical Home Implementation Manual, concepts of empanelment, team-based care, enhanced access, improving preventative services and evidenced-based care and the chronic care model and how to apply these concepts to their practice. The curriculum is taught with multiple modalities including didactics, computer modules and direct patient care. In addition, all residents will partake in an initial PCMH orientation and will be evaluated with the following methods: direct observation; written evaluation; 360 evaluation; patient surveys; and rotation evaluation.

During DY 7, ARMC faculty presented the following trainings to residents and other faculty in order to expand positive primary care exposure: 8/24/11, An Office-based Perspective of the Patient-Centered Medical Home; (2) 12/21/11, Introduction to Medical Homes; (3) 1/4/12, The Chronic Care Model; (4) 3/21/12, McKee Medical Home Model (Overview and Philosophy, Empanelment, The McKee Team, Enhanced Access, and Improving Preventative Services; (5)) 4/25/12Panel Management and Registry Training; (6) 5/9/12, The Chronic Care Model; (7) 5/9/12 Patient Centered Medical Home; (8) Orientation – IHI and ELM Modules ; and (9) Patient Centered Medical Home and Chronic Care Model Training materials and sign-in sheets on file.

A fully functional Patient Centered Medical Home not only improves health outcomes and increases patient satisfaction; it has also been shown to improve job satisfaction of both primary care practitioners and their clinic staff. Allowing our residents to hone their skills within these new models of care will give them the techniques and confidence needed to be successful in primary care after they graduate.

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

Achievement Value 1.00

Process Milestone:

(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Category 1: Increase Training of Primary Care Workforce

Process Milestone: _____
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Process Milestone: _____
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Improvement Milestone: (14) Increase primary care training by recruiting for at least 2 additional primary care residents over baseline
(insert milestone)

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

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

Achievement: Yes

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

3/31/12 - On 11/23/11, ARMC received notification from the American Osteopathic Association of "Approval of Increase in Six (6) positions from Eighteen (18) to Twenty-four (24)." As of 12/9/11, ARMC's Residency Program was interviewing applications for eight (8) PGY 1 residency positions for the 2012/13 Academic Year; this is an increase of two (2) residency positions for the 2011/12 Academic Year (See AOA residency notification letter on file with ARMC).

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

Achievement Value: 1.00

Category 1: Increase Training of Primary Care Workforce

Improvement Milestone: ______________________________
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Improvement Milestone: ______________________________
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Improvement Milestone: ______________________________
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Improvement Milestone: ______________________________
(insert milestone)

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

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

Category 1: Increase Training of Primary Care Workforce

Achievement	N/A
If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:	*
DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	*
Achievement Value	

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/30/2012

REPORTING ON THIS PROJECT: * Yes

Category 1: Implement and Utilize Disease Management Registry Functionality

Below is the data reported for the DPH system.
* *Instructions for DPH systems: Please select above whether you are reporting on this project. If 'yes', please type in all of your DY milestones for the project below and report data in the indicated boxes (*).*
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The black boxes indicate Milestones and will automatically populate and flow to summary sheets
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Implement and Utilize Disease Management Registry Functionality

DY Total Computable Incentive Amount: * $ 5,555,640.00

Incentive Funding Already Received in DY: * $ 2,430,592.50

Process Milestone: (21) Re-implement a functional disease registry (diabetes) at one of ARMC's FHCs
(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

3/31/12 - ARMC has made strides develop its current registry into a fully-functional reporting registry system. As of 12/31/11, ARMC staff is able to manually enter patient demographics, vitals, labs, medications and visits into the registry system. In addition, the registry is able to manually identify groups of patients as requested. As such, it has been determined that ARMC has completed 25% of this milestone. For the remainder of DY 7, ARMC will continue to focus its efforts on implementing a fully-functional disease registry system.

9/30/12 - ARMC implemented a functional disease registry for diabetic patients at the Fontana Family Health Center (FHC). In developing and then re-implementing the disease registry, ARMC's Information Technology (IT) department converted the old CDEMS registry database to a SQL database to secure the necessary data and make it accessible to multiple users. After the conversion, IT was able to download certain data from the hospital's information system (Meditech) into the SQL database; from there information flows to an Access database reporting tool as a front-end reporting device for providers. Providers and clinic staff are now able to enter and retrieve data from the system as necessary for reporting and patient care services as specified with the medical home and chronic care models.

The disease registry tracks: patients who have had an A1c test within the past 12 months; patients' most recent HbA1c levels; patients' LDL levels; patients' blood pressure levels; and patients with self-management goals. Through the use of the registry, FHC staff can pull reports based on patient population, those meeting/not meeting goals, and/or specific patients assigned to providers for care.

ARMC is also participating in the Safety Net Institute's (SNI) Medical Home Collaborative which is designed to help safety net primary care clinics become high-performing patient-centered medical homes (PCMHs) with a particular focus on improving chronic illness care for diabetes patients. As part of this Collaborative, ARMC is required to send monthly reports from the diabetic registry.

This has been one of our most challenging milestones to achieve as the registry had to be rebuilt almost entirely. Physicians and IT staff met weekly for several months to get the system operational. Through development and implementation, we have learned that ongoing maintenance of the registry will require considerable resources. For example, the staff have been challenged with intermittent network interruptions which caused some access issues in utilizing the registry on a day-to-day basis. IT has been working on this issue and will be adding more bandwidth at the hospital to account for the information overload that is being sent to the hospital's main server. This will be resolved in early DY 8. Despite this, clinicians and staff at the test site FHC are engaged and excited about the opportunity to obtain these helpful patient reports at the point of care.

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

Achievement Value 1.00

Category 1: Implement and Utilize Disease Management Registry Functionality

Process Milestone: (22) Conduct training to at least 25% of ARMC FHC staff on populating and using the registry function

(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

3/31/12 - On 12/21/11, Kathy Adams, RN, Fontana FHC Clinic Supervisor, provided a training session to half of the Fontana FHC clinic staff. The number of staff trained accounts for half of the required 25% to complete this milestone (see sign in sheet and training guide from 12/21/11). The remainder of the staff was trained in February 2012 and ARMC will be including that during the 2nd half reporting period for DY 7.

9/30/12 - All the staff at the Fontana Family Health Center (FHC) have been trained on utilizing the registry, which accounts for greater than 25% of the total ARMC FHC staff, therefore fulfilling the milestone requirements for DY 7. Training included an instructional overview/purpose of the diabetes registry, a registry "how-to" and a hands-on lab. During the hands-on lab, staff were required to enter patient data and documents into the registry as well as pull reports to demonstrate competency with the system. With staff being able to effectively use the registry, it allows for panels to provide population management as a part of the Patient Centered Medical Home. Sign-in sheets and training documents are on file with ARMC

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

Process Milestone: (23) Demonstrate registry automated reporting ability to track and report on patient demographics, diagnoses, patients in need of services or not at goal, and preventive care status

(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

9/30/12 - ARMC's diabetes registry is functional and automated for patients at the Fontana Family Health Center. Evidence of automation includes monthly reports submitted to the Safety Net Institute for the Patient Centered Medical Home Collaborative (focus on improving chronic illness care for diabetes patients). ARMC must report statistics for diabetes patients with A1c on file in the past year, an A1c<8%, an LDL<100, BP<140/90mmHg, and those with self-management goals (reports on file with ARMC).

In addition to the Collaborative reports, ARMC staff can now pull reports related to patients in need of services or not at goal. For example, a patient care team member will run a report for patients who have not had a mammogram in the past two years; the doctor will then view the report then work with his LVN to contact those patients in need of an exam and schedule them an appointment. This type of report can also be run for diabetic patients who have not had an HgA1c drawn during the past year, thus requiring services. Another example of reporting capability is the ability to run a report of patients who are not at goal, specifically, diabetic patients who have an HgA1c higher than 8% when the goal has been set at less than 8%

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

Category 1: Implement and Utilize Disease Management Registry Functionality

Process Milestone: _____
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Process Milestone: _____
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Improvement Milestone: (24) Enter at least 400 diabetic patients into the registry
(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

3/31/12 - As of 12/31/11, over 400 diabetic patients have been identified and added to ARMC disease registry (see reports on file).

9/30/12 - In DY 7 ARMC began to enroll all patients with two or more visits to their assigned Family Health Center (FHC) into the health maintenance registry; those patients who were identified as having diabetes were included in the diabetes portion of the health registry. We realize that as we move forward with DSRIP and improving the overall health of ARMC's patient population we will have to track additional diseases and health statuses to get the most benefit out of the registry. Currently ARMC's registry does not allow for additional disease states and measures. This will be addressed during DY 8.

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

Achievement Value 1.00

Category 1: Implement and Utilize Disease Management Registry Functionality

Improvement Milestone: ______________________
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Improvement Milestone: ______________________
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Improvement Milestone: ______________________
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Category 1: Implement and Utilize Disease Management Registry Functionality

Improvement Milestone: _____

(insert milestone)

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

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/30/2012

REPORTING ON THIS PROJECT: * Yes

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 (*).*
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The black boxes indicate Milestones and will automatically populate and flow to summary sheets
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Expand Specialty Care Capacity

DY Total Computable Incentive Amount: * $ 5,555,641.00

Incentive Funding Already Received in DY: * $ 3,055,602.55

Process Milestone: (38) Collect baseline for number of days to process referrals and wait time from receipt of referral to actual referral appointment
(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

3/31/12 - As of 12/31/11, based on a manual count performed, data gathered and statistical probabilities can be reported on in relation to number of days to process referrals and wait time from receipt of referral to actual appointment (data on file with ARMC). As such, 50% of this milestone has been completed. A definitive baseline will be collected and reported on as of 6/30/12.

9/30/12 - As of 6/30/12, ARMC has established the baseline for the number of days to process referrals and number of days from referral to actual appointment for 25 specialty services, including:

Anticoagulation (65 days to process referrals: 78 days from referral to actual appointment); Audiology (33 days to process referrals: 217 days from referral to actual appointment); Breast Surgery (21 days to process referrals: 66 days from referral to actual appointment); Burn (38 days to process referrals: 72 days from referral to actual appointment); Cardiology (137 days to process referrals: 171 days from referral to actual appointment); Dental (37 days to process referrals: 128 days from referral to actual appointment); Endocrinology (94 days to process referrals: 207 days from referral to actual appointment); ENT (122 days to process referrals: 290 days from referral to actual appointment); GI (304 days to process referrals: 616 days from referral to actual appointment); Hepatology (106 days to process referrals: 364 days from referral to actual appointment); Nephrology (35 days to process referrals: 176 days from referral to actual appointment); Neurology (97 days to process referrals: 168 days from referral to actual appointment); Neurosurgery (167 days to process referrals: 99 days from referral to actual appointment); Obstetrics (71 days to process referrals: 72 days from referral to actual appointment); Opthalmology (135 days to process referrals: 241 days from referral to actual appointment); Oral Surgery (64 days to process referrals: 215 days from referral to actual appointment); Plastic Surgery (9 days to process referrals: 59 days from referral to actual appointment); Pulmonary (89 days to process referrals: 140 days from referral to actual appointment); Rheumatology (450 days to process referrals: 486 days from referral to actual appointment); Surgery (118 days to process referrals: 158 days from referral to actual appointment); Urology (233 days to process referrals: 343 days from referral to actual appointment); Vascular Surgery (56 days to process referrals: 132 days from referral to actual appointment); Women's Health (144 days to process referrals: 214 days from referral to actual appointment); Women's Health Genetics (58 days to process referrals: 77 days from referral to actual appointment); Women's Health High Risk (19 days to process referrals: 137 days from referral to actual appointment).

In DY7 we seriously underestimated the difficulty we would have in automating the tracking of this data. The baseline data as well as most of the referral tracking reports had to be obtained by hand; a process so laborious we could not provide feedback quickly enough to the specialists. Developing an automated system and testing it in a clinic setting took several months. We did use the IHI Model for Improvement starting in a small clinic where the clinicians were enthusiastic. We identified problems and were able to test solutions allowing us to roll it out further.

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

Achievement Value: 1.00

Category 1: Expand Specialty Care Capacity

Process Milestone: (39) Expand the ambulatory care medical specialties referral management department by implementing a revamped specialty referral process

(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

3/31/12 - ARMC's referral process has been revamped as such: (1) Referral duties have been created and implemented for the Specialist, Referral Center and Clinic Staff. This information outlines who is responsible for what with the new process. (2) ARMC Automated Tracking System (ARTS) has been developed which will electronically track referrals in the system to more accurately determine where a referral is in the process and provides the ability to determine backlog for future improvements. (See documentation on file at ARMC).

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

Process Milestone: (40) Establish specialty care guidelines for the high/most impacted medical specialties

(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

3/31/12 - As of 12/31/11, ARMC has established specialty care guidelines/protocols for the Ear, Nose and Throat clinic, which has been identified as one of the hospitals high/most impacted medical specialties. As such 25% of this milestone has been completed. (See guidelines/protocols on file with ARMC). The DSRIP team is working with other clinics that have been identified as high/most impacted to establish specialty care guidelines/protocols. This process will be completed by 6/30/12.

9/30/12 - As of 6/30/12, ARMC has developed specialty care guidelines/protocols for four of its most impacted clinics including, Ear, Nose and Throat, Cardiology, Gastroenterology and Hepatology (liver) to ensure patients are receiving appropriate specialty referrals. These guidelines assist the referring provider determine the best approach for treatment and/or when to refer a patient to a specialist. The guidelines specify which clinical indicators must be met for referral as well as which documents to include when requesting a referral (i.e. description of symptoms, medication lists, discharge summary, if applicable, copies of procedure reports, lab work and tests) in order to better facilitate the referral once it reaches the specialist. The use of specialty care guidelines in these clinics has improved communication between primary care provider and specialty physicians. In addition, the guidelines allow for the primary care providers to extend beyond their normal scope and provide more detailed evaluations and treatment to their patients as opposed to an immediate referral which may not be necessary. These guidelines have been distributed to the 4 groups of specialty care physicians and all of the primary care providers via memo and specialty guides.

Dr. Roberts (ENT physician) was instrumental in developing the specialty care guidelines/protocols template for this milestone. In doing so, Dr. Roberts drafted specialty care guidelines for ENT and then met with physicians and nurses to discuss specifically what worked and what didn't in the guidelines; he would then revise the guidelines and continue this process until it was clear that the (template) guidelines were user friendly and easy to work with. Once the guideline template was developed, Dr. Roberts in collaboration with Ambulatory and Referral Services worked with the other three specialty groups to develop their own guidelines for referrals. This Plan, Do, Study, Act (PDSA) process proved to be effective; making it easy to roll out and train on as there was consistency with the format.

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

Category 1: Expand Specialty Care Capacity

Process Milestone: (41) Train 15% of primary care providers, specialists and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties (3 ARMC FHCs and 2 specialty clinics)

(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

3/31/12 - ARMC's Referral Department provided a large education/training session to all of the Family Medicine Practitioners (see list on file as well as formal notification letter and New Outpatient Referral Form) as well as the Ambulatory Clinic Staff (see sign-in sheet on file as well as minutes from education/training session). Training included new processes and guidelines for submitting, accepting and processing referrals as well as a detailed introduction to ARMC's Automated Referral Tracking System. This training accounts for over 15% of the primary care providers, specialists and clinic staff.

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

Process Milestone: (42) Provide reports on number of days to process referrals, and wait time from receipt of referral to actual referral appointment

(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

3/31/12 - By 6/30/12, all medical specialty clinics which have been identified as high/most impacted will be added to the ARTS system to which reports of number of days to process referrals, and wait time from receipt of referral to actual referral appointment will be accessible and reportable.

9/30/12 - As of 6/30/12, ARMC has been able to add clinics to its Automated Referral Tracking System (ARTS) in order to better coordinate the specialty referral process. Reports from ARTS show the following: March 2012: Orthopedics, 61 days to process – 129 days to appointment; Pediatric Orthopedics, 81 – 118; Spine, 51 – 45. April 2012: Oncology, 15 – 95; Orthopedics, 60 – 138; Pediatric Orthopedics, 60 – 154; Spine, 60 – 154. May 2012: Dental, 34 – 66; Oncology, 22 – 136; Orthopedics, 47 – 170; Pediatric Orthopedics, 54 – 263; Spine, 13 – 58. June 2012: Dental, 19 – 86; Oncology, 11 – 181; Orthopedics, 21 – 167; Pediatric Orthopedics, 26 – 178; Spine, 12 – 122. These reports show that the number of days to process referrals is steadily decreasing each month. The decrease is a result of having the actual referrals available for review on the same day they are received into the system. In addition, physicians and staff become more familiar with ARTS thereby more efficiently processing referrals through the system.

During DY 8, ARMC will be working to add all specialty services to ARTS, which will allow staff timely access to information thus improving the tracking and flow of referrals and the ability to identify and address issues in a timely fashion. Such conveniences are designed to reduce the wait times for specialty appointments. ARMC's Ambulatory Services Department is working with the County's Information Services Department to expand ARTS, which will allow each specialist access to patient information to assess and address needs regarding the referrals.

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

Category 1: Expand Specialty Care Capacity

Improvement Milestone: _____
(insert milestone)

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

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

Achievement N/A

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

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

Achievement Value

Improvement Milestone: _____
(insert milestone)

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

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

Achievement N/A

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

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

Achievement Value

Category 1: Expand Specialty Care Capacity

Improvement Milestone: ____________________
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Improvement Milestone: ____________________
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Improvement Milestone: ____________________
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/30/2012

REPORTING ON THIS PROJECT: * Yes

Category 2: Expand Medical Homes

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

Expand Medical Homes

DY Total Computable Incentive Amount: * $ 7,640,479.00

Incentive Funding Already Received in DY: * $ 3,342,709.56

Process Milestone: (49) Put in place policies and systems to enhance patient access to the medical home
(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

3/31/12 - As of 12/31/12, ARMC has updated its policies regarding patient access to the Medical Home (Family Health Center). Ambulatory Care Service Policy No. 301.00 (on file), addresses patient access to the medical home, including confirming and scheduling for appropriate Primary Care Provider (PCP), clinic location and insurance verification. In addition, staff have been trained (systems in place) to correctly identify patients' medical homes, PCP and schedule accordingly, all of which effectively enhance the patients' access to their medical home.

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

Achievement Value: 1.00

Category 2: Expand Medical Homes

Process Milestone: (50) Reorganize staff into primary care teams responsible for the coordination of care

(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

3/31/12 - ARMC is in the process of hiring the necessary staff to fully implement the medical home model. Individuals have, and are being, interviewed, hired, trained and formalized into primary care teams responsible for the coordination of care during the 2nd half of DY 7. This information will be reported in the Final Report for DY 7.

9/30/12 - As of 6/30/12, the McKee Family Health Center (FHC) procedures have been changed to reorganize staff into primary care teams, or pods/podlets. The FHC has 2 pods which consist of 4,000 patients and 7 podlets to accommodate the patient load. The pods/podlets are designed to have more patient care provided by non-PCP members of the team. With the addition of pods and podlets, position descriptions have changed to reflect the new duties:
The PCP is no longer defined as someone who joins or develops a system to provide patient requested care on a 24 hour a day, 7 day a week basis. The PCP will now be held accountable for whether an assigned patient has “appropriate” outcomes for specific health conditions and whether they received USPSTF recommended preventative services. In fact, it will be the expectation that the PCP will track and know his/her rates and develop plans to continuously improve those rates.
The Ambulatory Care Chronic Disease Case Manager will work with complex patients to set self-management goals and to follow with patients to ensure success.
Nurses will provide patient care via nurse visits in clinics as well as phone and email visits. They will be responsible to teach and supervise other members of the team who are providing patient education, medication reconciliation and self-management goal setting and coaching.
LVNs will serve as panel managers for the pods, addressing requests to change PCPs, monitor sizes of panels and empanelment, quality measures, and teach/supervise Clinic Assistants as well as oversee “outreach” for the panel as a whole.
Clinic Assistants will perform self-management support, patient education for common clinical conditions and medication reconciliation.
Clerks will improve transitions in care by coordinating referrals and participate in ensuring compliance with evidence-based guidelines for preventative services by running reports of patients who need such services and contacting them to set up the service.
The FHC Clinic Supervisor is responsible for the implementation and maintenance of pods and podlets. It is her duty to ensure that staff are up to date on training and competent in their new job roles.

ARMC's Administration played a crucial role in facilitating the implementation of pods and podlets at the FHC by working with downtown County Human Resources to push through the hiring of Clinic Assistants which are critical to the Medical Home. Typically the new hire process can take several months before a new staff member is hired. Administration was able to circumvent this process and speed up the hiring therefore assisting in the implementation of the Patient Centered Medical Home at the FHC.

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

Category 2: Expand Medical Homes

Process Milestone: (51) Establish criteria for medical home assignment
(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

3/31/12 - In developing ARMC's Medical Home Model, definitions and criteria were developed and implemented to assign patients to specific medical homes. (See Medical Home Implementation Manual on file with ARMC). Through this criteria, patients will be assigned to a specific Medical Home and receive educational materials regarding how ARMC's Medical Home functions (i.e. what a patient can expect from their Medical Home and what the Medical Home expects from them).

9/30/12 – Administration and Ambulatory Services collaborated to develop a memo that was sent to ARMC staff and clinical providers which defined ARMC's Patient Centered Medical Home (PCHM) as well as designating how patients will be assigned to a PCHM. Excerpts from the memo are as follows: "An important aspect of our DSRIP plan is the creation and implementation of a Medical Home, whereby a patient will receive comprehensive longitudinal care. Services of the Medical Home include population management using disease and preventive health registries, use of the Chronic Care Model for diabetes management, health coaching to enhance patient engagement in personal health and multidisciplinary team-based care where each member works at the top of his or her license. ARMC's Medical Home philosophy is, "Any patient who wishes to establish an ongoing relationship with a group of professionals, all with a common goal of maximizing that patient's health and wellbeing, deserves to be in a medical home. Therefore, initially we will define any patient who is willing to keep a second appointment at one of ARMC's Family Health Centers, as agreeing to a Medical Home relationship." Although this process will begin with the FHCs our long-term goal is to encourage all ARMC patients to join a medical home." Through the distribution of this memo staff were further introduced to the PCHM and how it will play a valuable role in the future of ARMC's population health management.

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

Process Milestone: (52) Develop training materials for medical homes
(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

3/31/12 - ARMC's DSRIP team has developed training materials to implement its Medical Home Model. Training materials include information on: (1) Overview and Philosophy; (2) Empanelment; (3) The Family Health Center Team; (4) Enhanced Access; and (5) Improving Preventative Services. (See Medical Home Implementation Manual on File with ARMC).

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

Category 2: Expand Medical Homes

Process Milestone: (53) Designate/hire Panel Managers to support and oversee panel management at the three ARMC FHCs (3 Panel Managers)

(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

3/31/12 - On 12/27/11, A. Gutierrez, LVN, was assigned the new position duties of Panel Manager for the McKee FHC. A. Gutierrez will be responsible for identifying population management priorities, collaborate with healthcare teams to implement population management, enter data into/maintain disease registries, perform patient outreach, facilitate patients' access to care, provide support to Health Education staff regarding patient self-management goals and participate in community meetings (see new position description on file). Designation of A. Gutierrez as the Panel Manager for McKee FHC accounts for 33% completion of this milestone. This will be adjusted to account for a 25% completion of this milestone.

9/30/12 - As we became more knowledgeable about the patient centered medical home, we realized we needed more panel managers than just one for each clinic. After testing some of the concepts on a small scale with one physician champion and the first panel manager we adjusted our plan to include 2 panel managers for each pod. Therefore as of June 30 ARMC has designated/hired 7 panel managers, specifically; 3 at the McKee FHC; 2 at Westside FHC; and 2 at the Fontana FHC. We will continue to recruit until we achieve our goal of two panel managers per pod. Panel Managers are responsible for identifying population management priorities, collaborating with healthcare teams to implement population management, entering data into/maintain disease registries, performing patient outreach, facilitating patients' access to care, providing support to Health Education staff regarding patient self-management goals and participating in community meetings. With the addition of panel managers, ARMC revised the LVN position description to include panel management duties. With this revision, LVNs were trained on new duties, including registry use, addressing requests to change Primary Care Providers, monitor sizes of panels and empanelment, quality measures, and teach/supervise Clinic Assistants as well as oversee “outreach” for the panel as a whole. See signed position descriptions on file.

Dr. Raval is the designated physician champion-s for Medical Homes and Panel Management. He is also the program director for the family medicine residency program and has been instrumental in pushing forward the concept and process of the medical home model and panel management as well as encouraging physician engagement among all the providers.

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

Category 2: Expand Medical Homes

Process Milestone: (54) Train at least 25% of ARMC FHC staff on the medical home model
(insert milestone)

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

3/31/12 - As of 12/31/11, an initial group of ARMC FHC staff have received training (conference and in-house), accounting for 25% of the required 25% of all ARMC FHC staff. All additional staff will be trained on ARMC's Medical Home Model by 6/30/12. (See training schedules and attendance sheets on file with ARMC).

9/30/12 - As of 6/30/12, 25% of ARMC FHC staff (McKee Clinic) has been trained on the Patient Centered Medical Home (PCHM) model. Training sessions included; one-on-one training with panel managers with a focus on an introduction to PCMH, empanelment and the LVN's role as the Panel Manager, population management, assisting patients with setting self-management goals and how to coach patients on these goals (1/18, 1/20, 1/27); one-on-one training with the Clinic Assistants on how to perform basic patient education and medication reconciliation (1/27); empanelment training for LVNs (4/11); population management training specifically on increasing mammogram rates and practice session registry with Panel Managers (4/13); empanelment and hands-on registry training for primary care providers (PCPs) (4/25); introduction to PCMH from the Emergency Department perspective (5/8); empanelment and hands-on registry for PCPs (5/9); introduction to PCMH for LVNs (5/25); Nursing orientation to PCMH (6/7); What is Panel Management (6/19). In addition to the aforementioned in person classes, a training guide was developed, entitled, "Medical Home School Part 2". This training guide was distributed to the PCPs as a home-study, designed to delve more deeply into: (1) basic patient education that would be done by the Clinic Assistants for the big three (diabetes, hypertension and hyperlipidemia); (2) medication reconciliation; (3) action plans and coaching; and (4) quality improvement. Training documents and sign-in sheets are on file with ARMC.

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

Category 2: Expand Medical Homes

Process Milestone: (55) Implement the medical home model at one ARMC FHC (pilot)
(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

3/31/12 - ARMC is taking the necessary steps to implement the medical home model at its Family Health Centers, including, development of the medical home model, training staff, implementing a functional disease registry and hiring the necessary staff. This will be reported on in ARMC's DY 7 Final report.

9/30/12 - As of 6/30/12, ARMC had taken the necessary steps to implement the Patient Centered Medical Home (PCMH) at its McKee Family Health Center (FHC). To accomplish this, ARMC has: (1) adopted the principles and philosophy outlined in the joint definition of the Patient-Centered Medical Home by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA): "A patient-centered medical home integrates patients as active participants in their own health and well-being. Patients are cared for by a physician who leads the medical team that coordinates all aspects of preventive, acute and chronic needs of patients using the best available evidence and appropriate technology. These relationships offer patients comfort, convenience, and optimal health throughout their lifetimes."; and (2) incorporated the following attributes into its FHC, Access to care, Patient engagement, Care coordination, Team-based care, Clinical information systems with decision support, feedback to physicians and Transparency.

Specifically, ARMC has:
1. Developed a workable plan for empanelment with established criteria for medical home assignment.
2. Reorganized and supplemented the staff at McKee FHC into multidisciplinary primary care practice teams responsible for coordinated patient care.
3. Developed a way to track access by looking at the third-next available appointment for each primary care provider.
4. Developed a system to improve compliance with evidence-based preventive services recommendations.
5. Educated senior leadership and department heads on the PCHM.
6. Changed procedures so that pods are responsible for registering their own appointments and are working towards taking ownership of their messages.
7. Medical Directors meet monthly with Clinic Supervisors to discuss progress and challenges with the PCMH model.

ARMC realizes this is just the beginning of what will be a wholly transformative process. In order for our patients to reap the benefits of long-term improved health outcomes there is much work to be done. The physicians, nurses and clinical staff have committed to a continuous quality improvement program to improve our effectiveness with engaging patients and supporting their self-management skills.

An issue that has been addressed, and will continue to be addressed is the implementation of the PCMH model and the Electronic Health Record at the same time. Reports have shown it important to tackle one massive change at once, master it, and then move on to the next change. With DSRIP being rolled out during ARMC's planned implementation of its EHR, staff have had to work through many obstacles to keep both projects on track and moving forward.

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

Category 2: Expand Medical Homes

Improvement Milestone: (56) At least 50% of new patients assigned to the pilot medical home receive their first appointment in a timely manner

(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

3/31/12 - ARMC is taking the necessary steps to implement the medical home model at its Family Health Centers, including assigning new patients to the medical home and ensuring they receive their first appointment in a timely manner as per the assigned metrics. This will be reported on in ARMC's DY 7 Final report.

9/30/12 - Prior to implementing the Patient Centered Medical Home (PCHM) model, ARMC did not have a way to track how long it took for individual patients to get an appointment at any of our primary care clinics. Most of our patients were not part of a health plan so we would not know they desired an appointment until they called. We did periodically assess our next available slots but these were generally much less than 120 days. However, as part of the new low income health plan, ARMC was able to develop a list of health plan patients newly assigned to McKee FHC (our first Medical Home) in February 2012. Therefore, we were able to analyze these specific individual patients to determine if they had established care prior to the "assignment date" + 120 days deadline. For the months of February – June, 1,206 new patients were assigned to the McKee FHC. Of these 1,206 patients assigned, 778 (or 65%) had established care before the assignment date +120 days deadline.

Tracking this data proved to be a challenge for ARMC. The information must be determined by looking up each individual patient in the system to determine the date seen in the clinic. We are evaluating the possibility of automating the process to allow monitoring of multiple clinics in the future. As of the end on June 2012, have been unable to identify an automated system and therefore have no specific go-live date.

Since the introduction of the PCMH model, pods are being proactive about patient receiving their appointments in a timely manner. The staff receives lists of new patients and reaches out to them with a phone call or letter to set up their first appointment and/or answer any questions they may have about the PCMH.

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

Achievement Value 1.00

Improvement Milestone:

(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Category 2: Expand Medical Homes

Improvement Milestone: _____

(insert milestone)

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

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

Achievement N/A

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

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

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/30/2012

REPORTING ON THIS PROJECT: * Yes

Category 2: Expand Chronic Care Management Models

Below is the data reported for the DPH system.

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

* The yellow boxes indicate where the DPH system should input data
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:	* $ 7,640,479.00
Incentive Funding Already Received in DY:	* $ 1,528,095.80

Category 2: Expand Chronic Care Management Models

Process Milestone: (64) Implement the Chronic Care Model for diabetes at one ARMC FHC (pilot)

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	0.50
Denominator (if absolute number, enter "1")	*	1.00
Achievement		0.50
If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:	*	No

3/31/12 - ARMC is in the process of fully implementing the Chronic Care Model at its Fontana Family Health Center. Chronic Care Model development and training have been taking place during the first half of DY 7 and efforts are being made to complete the training and implement the Chronic Care Model during the 2nd half of DY 7. This will be reported on in ARMC's DY 7 Final report.

9/30/12 - As of 6/30/12, half of the Fontana Family Health Center (FHC) clinic staff is heavily involved in performing Plan, Do, Study, Act (PDSA) cycles to improve the care of our diabetic patients. ARMC has plans to add the rest of the clinic staff in early DY 8, and therefore will be requesting half of the milestone credit for implementing the Chronic Care Model (CCM) for diabetes at its Fontana Family Health Center (FHC).

Though all Fontana FHC staff have been trained on the CCM, we were unable to implement the model clinic-wide due to several issues that we didn't anticipate. First the disease registry implementation took longer than expected. It took several months for the Information Technology and Ambulatory departments to develop, test and implement the actual registry. Likewise, the recruitment and hiring of the Ambulatory Chronic Case Manager was delayed as a result of human resources issues. We did attempt to accelerate implementation by developing two interdisciplinary process improvement teams. Both teams performed multiple Plan, Do, Survey, Act (PDSA) cycles and have made progress in the care of their diabetic patients, however we did not have enough time to add all the Fontana FHC providers by June 30, 2012. In DY 8 the all providers and clinic staff will be fully engaged in the CCM, working in huddles, self-management support, follow-up and planned visits.

Through the Chronic Care Model, Fontana FHC is monitoring and measuring the following for its diabetic patients: patients who have an A1c on file within the last 12 months, patients with an A1c < 8%, patients with an LDL <100, patients whose BP is <140/90, and those patients who have a documented self-management goal within the past 12 months.

Prior to the implementation of the registry, ARMC didn't have the means to perform population management for diabetes, and therefore has no comparative data to measure against. With the implementation of the registry and Chronic Care Model, Fontana FHC's PCPs and health teams can now monitor their patient's health data and provide enhanced health management. This initial data will be used as the baseline for future years to measure progress in chronic care management.

One aspect of the CCM is the introduction of the "planned visit" at the FHC. For example, patients will be scheduled for a diabetic care visit. Prior to this visit, the patient is asked to complete a questionnaire/form, specific to their medical condition. When the patient arrives for their visit, the pod will conduct a "huddle", review the patient's questionnaire/form to determine what is special about this patient visit and the care that should be provided. The assigned PCP will see the patient and then direct the patient to a member of their pod or a co-pod member for specialized care services based on their current health condition (i.e. developing or focusing on current self-management goals). Patients then receive a follow-up phone call the first week after their appointment and a call every two weeks for three months until their next visit. In providing "planned visits" and follow-up phone calls the FHC staff are ensuring that their patients are staying on track and focused with their self-management goals and chronic condition. These visits are much more prescriptive and result in more effective patient visits and healthier outcomes.

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

Category 2: Expand Chronic Care Management Models

Process Milestone: (66) Train at least 25% of staff in the Care Model

(insert milestone)

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

3/31/12 - On 10/26/11, ARMC's core Chronic Care team attended the UCSF Center for Excellence in Primary Care Health Coach Training in Pasadena. This conference included training on health coaching and collaborating with patients. As of 12/31/11, the members of the Core team have provided informal training/education to the Fontana Family Health Center staff members pertinent to ARMC's Chronic Care Model during team meetings. Formalized training is scheduled during the remainder of DY 7 and will be reported on in ARMC's DY 7 final report.

9/30/12 - As of 6/30/12, all of the Fontana Family Health Center (FHC) providers and staff have received formalized training on the Chronic Care Model, specific to diabetes, accounting for 25% of ARMC's primary care staff.

The curriculum included:

(1) Self-Management - ARMC will empower and prepare patients to manage their own health care. Patients will be encouraged to set goals, identify barriers and monitor their own diabetes.
(2) Decision Support - ARMC will promote care consistent with scientific data and patients preferences. Clinicians will have convenient access to the latest evidence-based guidelines for diabetes care. Staff will share evidence-based guidelines for diabetes with patients to encourage their participation.
(3) Clinical Information Systems - ARMC will use the ARMC developed registry to facilitate efficient and effective care. This system will provide the FHC Providers with an inclusive list of patients with diabetes. The registry provides the information necessary to monitor patient health status and reduce complications. It will allow clinicians to: identify relevant subpopulations for proactive care; facilitate individual patient care planning; and monitor performance of practice team and care system.
(4) Delivery System Design - ARMC will assure effective and efficient care and promote self-management skills to the patients. Staff will aim to encourage real problem solving skills with patients and maximize the potential of new decision support mechanism and new clinical information system (registry). Staff will implement proactive planned visits which incorporate patient's self-management goals. The system of visits will employ the healthcare skills of several team members, not just the provider.
(5) Organization of Health Care - ARMC will create an organization that provides safe, high quality care to persons with diabetes. The strategic plan is to apply the Chronic Care Model across the ARMC delivery system. Leading clinicians in this effort will be visible at all levels of the medical center hierarchy.
(6) Community - ARMC will mobilize community resources to better meet the needs of diabetic patients. It is imperative to interact with local school, government, non-profit and faith-based organizations to bolster our ability to provide a comprehensive chronic care management diabetes program (training documents and sign-in sheets on file with ARMC).

In addition to training the current FHC staff, all new staff and residents receive Chronic Care Model training during their orientation.

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

Category 2: Expand Chronic Care Management Models

Process Milestone: (67) Formalize multi-disciplinary teams in one ARMC FHC

(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

3/31/12 - After attending the UCSF Center for Excellence in Primary Care Health Coaching Training, ARMC's Core Chronic Care team has been developing formalized multi-disciplinary teams at the Fontana Family Health Center (FHC). The goal for this FHC is to have two Pods, each comprised of two Teams who are responsible for utilizing the Chronic Care Model with the identified patient population (diabetic patients). Teams will perform the following elements of the Chronic Care Model to include, taking vitals, reconciling medications, setting self-management goals and providing education on the chronic condition. ARMC will report on its formalized multi-disciplinary teams in the DY 7 final report.

9/30/12 - As of 6/30/12, ARMC's Fontana Family Health Center (FHC) has formalized the clinic into two multi-disciplinary teams. Both teams consist of 6 members, 1 physician, 1 nurse, 1 social worker, 2 clinic assistants and 1 information technology specialist.

The Primary Care Provider (PCP) is responsible for examining their patients, prescribing treatments and medications, and using labs, X-rays, etc. to determine how well controlled the patient's diabetes is. With the introduction of the Chronic Care Model, providers are involving the patients as a member of the healthcare team and more emphasis is placed on prevention. The use of the Registry helps the providers to identify trends in patient care, and contact those patients in need of further care to improve overall health outcomes.

The Nurse is responsible for educating patients on their chronic conditions, teaching medication administration, medicine reconciliation, assisting in setting self-management goals, and facilitating specialty and ancillary care. They are also essential in utilizing Registry information to monitor HGB A1C, LDL and BP results, planned visits, follow ups with PCP and Specialists to improve outcomes.

The Clinic Assistants are responsible for taking vitals, reconciling medications, assisting in establishing self-management goals, educating patients on their chronic condition, and utilizing the Registry to assist nurses with their duties.

The Social Worker will assist in locating outside educational resources and providing assistance to staff in patient goal setting.

The Information Technology Specialist is responsible for monitoring, managing and improving the Patient Registry.

The teams joined a multicentre collaborative (through SNI) and set goals for HgA1c, LDL and BP results as well as documented self-management goals for diabetic patients. The collaborative provided a coach for the teams during their weekly meetings. Using the registry, the teams posted their patient's results as well as the clinic as a whole each month. Multiple in-services were held to allow all support staff and PCPs throughout the clinic to learn how to use and have hands-on practice with the registry. All the clinic assistants were taught how to provide basic patient education for diabetic patients.

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

Category 2: Expand Chronic Care Management Models

Process Milestone: (68) Designate/hire a chronic disease case manager to provide case management services at one of ARMC's FHCs

(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

3/31/12 - On 1/9/12, ARMC hired a Chronic Disease Case manager to provide case management services at its Fontana Family Health Center. As it was after 12/31/12, it will be reported in the final report for DY 7.

9/30/12 - ARMC's Ambulatory Associate hired L. West as a Case Manager in January 2012. Ms. West is a nurse case manager specializing in ambulatory care of chronic diseases. As the Case Manager, some of her duties include: regularly assessment of disease control, adherence and self-management status, adjust or communicate patient's treatments needs to providers; use of adult learning theory when providing patient education; encourage patients to become increasingly active participants in their care; provide chronic disease skills training; assist patients with emotional impact of chronic disease; provide intense follow-up on a routine basis; assist patients with navigation through the health care process; enter/retrieve data from the registry; prepare patient charts and patients for planned visits; and assist patients in setting self-management goals. Copy of position description on file. ARMC plans to hire additional ambulatory chronic disease case managers for its other primary care clinics in DY 8.

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

Process Milestone:

(insert milestone)

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

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

Category 2: Expand Chronic Care Management Models

Improvement Milestone: (65) Apply the Chronic Care Model to one targeted chronic disease (diabetes) which is locally prevalent

(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

3/31/12 - ARMC has applied its Chronic Care Model to patients with diabetes, which is locally prevalent in its patient population. ARMC will be following the Chronic Care Model developed by Ed Wagner, MD, MPH, Director of the MacColl Institute for Healthcare Innovation, Group Health Cooperative of Puget Sound described by Improving Chronic Illness Care (ICIC) program supported by the Robert Wood Johnson Foundation. The Model for the diabetic population will include, self-management, decision support, clinical information system, delivery system design, organization of health care and community. According to the Healthy San Bernardino website, 10.6% of San Bernardino County residents have been diagnosed with diabetes. In 2010, an estimated 25.8 million people, or 8.3% of the population had diabetes. San Bernardino County exceeds this amount and therefore, ARMC's DSRIP team has chosen diabetes as a targeted chronic disease in which to apply its Chronic Care Model.

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

Achievement Value 1.00

Improvement Milestone:

(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Improvement Milestone:

(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Category 2: Expand Chronic Care Management Models

Improvement Milestone: _____
(insert milestone)

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

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

Achievement N/A

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

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

Achievement Value

Improvement Milestone: _____
(insert milestone)

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

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

Achievement N/A

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

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

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/30/2012

REPORTING ON THIS PROJECT: * Yes

Category 2: Redesign Primary Care

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

Redesign Primary Care

DY Total Computable Incentive Amount: * $ 7,640,479.00

Incentive Funding Already Received in DY: * $ 2,546,826.33

Process Milestone: (79) Implement a practice management system
(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

3/31/12: - On 12/6/11, the County of San Bernardino, Board of Supervisors approved an Agreement between ARMC and The Camden Group for consulting services related to patient visit redesign, specifically to implement a practice management system (see Agreement No. 11-865). As part of this agreement, Camden will serve as the facilitator and project manager of ARMC clinic redesign, perform a gap analysis, facilitate task force meetings, manage implementation of the redesign process, host regular meetings with Administration, create metrics, tools and dashboard reports and train the necessary staff.

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

Achievement Value: 1.00

Category 2: Redesign Primary Care

Process Milestone: (80) Implement patient visit redesign at one ARMC FHC (pilot)
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	0.75
Denominator (if absolute number, enter "1")	*	1.00
Achievement		0.75

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

3/31/12 - The Camden Group had a "kick-off" meeting with ARMC's Westside Family Health Center staff in early February. The implementation process for patient visit redesign is underway and will be reported on ARMC's final report for DY 7.

9/30/12 - As of 6/30/12, ARMC's Westside Family Health Center (FHC) has completed 3 of the 4 phases towards implementing patient visit redesign. (1) With the assistance of the Camden Group, the FHC staff implemented the Practice Redesign Dashboard which provides information on the status of the redesign project and the metrics that will be tracked regularly to monitor progress. Specifically the dashboard measures, call center scheduling, patient check-in, pre-visit/rounding, patient visit, patient discharge, referrals, urgent message, and medication refills. (2) Included in the dashboard are the following "future-state" metrics: patients are seen within 10 minutes of being roomed, patients are discharged within 45 minutes of registration, all patients leave with an after visit summary, staff satisfaction, provider satisfaction, patient quality/satisfaction (CG-CAPHS), referral requests processed within 2 days of receipt, messages completed within one day of receipt, forms completed within 2 days of receipt, and insurance is verified prior to the patient's appointment. (3) FHC staff worked with the Camden Group to map the patient visits from beginning to end to determine how the time is spent in the clinics and to identify the bottleneck. Bottlenecks included patients not providing forms during the rooming process, vitals are not taken consistently in the exam rooms, the Clinic Assistant goes to the front office twice during a patient visit, different processes exist to indicate that the patient is roomed, the provider has to "locate" their clinical staff for assistance, there isn't a consistent process to discharge a patient nor to schedule follow up visits, patients do not receive an after visit summary and the provider is giving the patient information that could be given by a Clinic Assistant or Nurse. (4) Phase 4 was not completed during DY 7 and therefore will be completed and reported upon in DY 8.

During DY 7, two multidisciplinary FHC teams (nurse, physician champion, clinic assistant, LVN, office assistants) along with a Camden consultant completed a prioritization exercise in which the work groups chose two areas to focus on for patient visit redesign. Both groups will look at redesigning patient access to incorporate the principles and requirements of the Patient Centered Medical Home, meet patient expectations for care and enable the FHC to deliver quality care in an efficient, effective manner. The groups will prepare a recommendation on the redesigned access work flows for Senior Leadership's feedback and approval. In addition, the groups will develop a patient care model that addresses: patient access and satisfaction, non-provider roles and staffing requirements, use of technology-optimization of the electronic medical record and work flows.

The first work group selected appointment access and will focus on the following for patients: access when needed and wanted to appointments; timely return of phone calls; timely referrals; minimum wait time; phones answered promptly; follow up appointment scheduled before leaving; contact using patient's preferred method of communication (email, text); and patient to see their own provider. In addition to the patient focused changes, the work group will focus on the following for staff: not be overwhelmed; ability to provide quality care and satisfy patients- enough time; appropriate training; effective communication between physicians, staff and patients; easy to use disease/health maintenance registry; and staff be engaged in development and maintenance of care processes.

The second team chose to work on clinic flow which will focus on the following for patients: minimum wait time; appointments, referrals and follow-up care processed in a timely manner; messages returned promptly; help in achieving health goals; leave with printed information on a care plan; and be involved in making informed decisions about their healthcare. In addition to the patient focused changes, the work group will focus on the following for providers and staff: Physicians/nurse practitioners only do those things that require a provider's license; appropriate panel size; proactive care planning occurs through team huddles with the clinical assistants; minimum waste time; assistance in dealing with unengaged patients; not be overwhelmed (ability to do today's work today), ability to provide quality care and satisfy patients (enough time, appropriate training); effective communication between physicians, staff, and patients; easy to use disease/health maintenance registry; and staff is engaged in development and maintenance of care processes.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	*	1.00
Achievement Value		0.75

Category 2: Redesign Primary Care

Process Milestone: (81) Train 25% of ARMC FHC staff on methods for redesigning clinics to improve efficiency (including primary care residents)

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	0.25
Denominator (if absolute number, enter "1")	*	1.00
Achievement		0.25
If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:	*	

3/31/12 - The Camden Group had a "kick-off" meeting with ARMC's Westside Family Health Center staff in early February. The training of ARMC FHC staff on methods for redesigning clinics to improve efficiency is underway and will be reported on ARMC's final report for DY 7.

9/30/12 - The Westside Family Health Center (FHC) staff is fully engaged in clinic redesign (see Milestone 80 projects), but has only taken the necessary planning steps thus far and therefore all of the training had not occurred as of 6/30/12. The Camden Consultants introduced redesign concepts and led multidisciplinary meetings in which the clinic staff and providers identified and rated the seriousness of problems to decide as a group the two most crucial processes on which to focus on for redesign.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	*	1.00
Achievement Value		0.25

Process Milestone:

(insert milestone)

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

Process Milestone:

(insert milestone)

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

Category 2: Redesign Primary Care

Improvement Milestone: ____________________
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Improvement Milestone: ____________________
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Improvement Milestone: ____________________
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Category 2: Redesign Primary Care

Improvement Milestone: _____
(insert milestone)

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

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

Achievement N/A

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

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

Achievement Value

Improvement Milestone: _____
(insert milestone)

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

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

Achievement N/A

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

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

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/30/2012

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:	*	$ 3,861,000.00
Incentive Funding Already Received in DY:	*	$ 3,861,000.00

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

3-31-2012:
ARMC has been working with The California Association of Public Hospitals' Safety Net Institute (SNI) and Press Ganey in preparation of the distribution of the first CG-CAHPS surveys. On 12/13/2011, ARMC renewed its contract with survey vendor Press Ganey. ARMC was informed by Press Ganey in December that there were additional AHRQ recommendations regarding CGCAHPS expected to be released in January and was provided with a revised CG-CAHPS survey template by SNI on 02/03/2012. ARMC has continued to work with Press Ganey to develop and test the revised upload file, and plan appropriate sample size/mix for implementing CGCAHPS at its 3 Family Health Centers. Expected initiation of survey distribution is fourth quarter of DY7.

9-30-2012:
Contract and Transition: A Request for Proposal (RFP) for Patient Satisfaction Surveys was released on April 4, 2011 with a submission deadline of May 2, 2011. Incumbent, Press Ganey was selected as survey administration vendor in the RFP process. Contract was signed December 13, 2011 and dialogue began between DSRIP PI personnel, Clinic Administrators, and ARMC Administration regarding transition of current Medical Practice Surveys distributed at all specialty clinics to a focus of CGCAHPS survey distribution at the 3 Family Health Centers.

Planning and Redesign: A goal of 12/2011 was set to begin the submittal of upload files to Press Ganey for survey distribution, however the timeline had to be re-evaluated due to the release of regulatory information. The Agency for Healthcare Research and Quality (AHRQ) did not report CG-CAHPS recommendations until January of 2012 and Press Ganey was unwilling to move forward with the survey redesign without analysis and recommendations from AHRQ.

In January of 2012 the AHRQ recommendations were finalized. On 2/3/2012 SNI finalized and distributed a CG-CAHPS prototype to all DPHs. ARMC collaborated with SNI and Press Ganey to develop a revision to the CG-CAHPS survey prototype that would accommodate both the AHRQ recommendations and DSRIP criteria. During this time ARMC staff worked with Press Ganey Information Management personnel to define sample-size and upload file structure/information. It was determined that best practice would be for ARMC to send a daily upload file to Press Ganey in order to allow for the detection of any errors in the file that may occur due to facility systems changes/upgrades.

Verification of the upload test files took place in May 2012. ARMC Performance Improvement staff reviewed the upload process with Press Ganey and ARMC Information Management personnel to ensure uploads would be submitted consistently and appropriately. In addition, a process was developed for ongoing auditing of the upload file content in order to verify data and address any errors quickly.

Implementation: On 5/15/2012 ARMC began administering CG-CAHPS in English and Spanish for all three Family Health Centers (Fontana, McKee, and Westside). Visit dates for the survey upload were retroacted to 4/1/2012, and continued forward.

Achievement	Yes
Achievement Value	1.00

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

Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme to the State *(DY8-10)*

Top-box score composite of all questions within this theme from all returned surveys:
Enter the percentage of responses that fell in the most positive response category *

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

Achievement: N/A

Achievement Value

Report results of CG CAHPS questions for "How Well Doctors Communicate With Patients" theme to the State *(DY8-10)*

Top-box score composite of all questions within this theme from all returned surveys:
Enter the percentage of responses that fell in the most positive response category *

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

Achievement: N/A

Achievement Value

Report results of CG CAHPS questions for "Helpful, Courteous, and Respectful Office Staff" theme to the State *(DY8-10)*

Top-box score composite of all questions within this theme from all returned surveys:
Enter the percentage of responses that fell in the most positive response category *

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

Achievement: N/A

Achievement Value

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

Report results of CG CAHPS questions for "Patients' Rating of the Doctor" theme to the State *(DY8-10)*

Top-box score composite of all questions within this theme from all returned surveys:
Enter the percentage of responses that fell in the response categories 9 and 10 *

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

Achievement: N/A

Achievement Value

Report results of CG CAHPS questions for "Shared Decisionmaking" theme to the State *(DY8-10)*

Top-box score composite of all questions within this theme from all returned surveys:
Enter the percentage of responses that fell in the most positive response category *

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

Achievement: N/A

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/30/2012

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:	*	$ 3,861,000.00
Incentive Funding Already Received in DY:	*	$ 1,930,500.00

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

Data Collection Source	*	Electronic medical record (EMR)
Numerator	*	30.0
Denominator	*	3,733.0
Rate		0.8

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):

03-31-2012:
Mid-Year reporting data was sourced from a combination of MediTech Reports and EMR chart abstraction. Obtained random sample of 325 patient charts from Fontana, McKee and Westside Family Health Centers for adult diabetic patients who had visited FHCs at least twice in DY6 (July 1, 2010-June 30, 2011). Patients from this population discharged from an inpatient stay with ICD-9 codes for diabetes short term complications during the reporting period (DY7 Mid-Year: between 07/01/2011 and 12/31/2011) counted toward the numerator. No patients matched this criteria within the validated 325-patient sample. Continue data collection for year-end DY7 reporting.

9-30-2012
Data Source and Improvements: Data was sourced from Meditech reports. Improvements to reports resulted in more reliable data capture for the diabetes population; 3,733 patients in DY 7 (population was sampled for mid-year reporting). Less than 1% of the FHC diabetic population (diabetic, 18-75, at least two FHC visits in DY6) was discharged from ARMC with ICD-9 codes for uncontrolled diabetes mellitus with mention of short-term or long term complications during Demonstration Year 7.

Improvements to Short-term complications/Uncontrolled DM measures: Any improvements to Category 3 population measures are based upon ARMC's ability to meet milestones outlined in Category 2 of the DSRIP plan. As ARMC progresses through the implementation of Category 2 initiatives, specifically:
• Development and management of the disease registry,
• Expansion of the Chronic Care model, and
• Patient Centered Medical home,
The expectation is that management of the Diabetic population will increase, resulting in population measure improvement.

Achievement	Yes
Achievement Value	1.00

Category 3: Care Coordination *(required)*

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

Data Collection Source	*	Electronic medical record (EMR)
Numerator	*	5.0
Denominator	*	3,733.0
Rate		0.1

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

03-31-2012
Mid-Year reporting data was sourced from a combination of MediTech Reports and EMR chart abstraction. Obtained random sample of 325 patient charts from Fontana, McKee and Westside Family Health Centers for adult diabetic patients who had visited FHCs at least twice in DY6 (7/1/2010-6/30/2011). Patients from this population discharged from an inpatient stay with ICD-9 codes for uncontrolled diabetes during the reporting period (DY7 Mid-Year: between 7/1/2011 and 12/31/2011) counted toward the numerator. Continue data collection for year-end DY7 reporting.

9-30-2012
Data Source and Improvements: Data was sourced from Meditech reports. Improvements to reports resulted in more reliable data capture for the diabetes population, 3,733 patients in DY 7 (population was sampled for mid-year reporting). Less than 1% of the FHC diabetic population (diabetic, 18-75, at least two FHC visits in DY6) was discharged from ARMC with ICD-9 codes for uncontrolled diabetes mellitus with mention of short-term or long term complications during Demonstration Year 7.

Improvements to Short-term complications/Uncontrolled DM measures: Any improvements to Category 3 population measures are based upon ARMC's ability to meet milestones outlined in Category 2 of the DSRIP plan. As ARMC progresses through the implementation of Category 2 initiatives, specifically:
• Development and management of the disease registry,
• Expansion of the Chronic Care model, and
• Patient Centered Medical home,
The expectation is that management of the Diabetic population will increase resulting in population measure improvement.

Achievement	Yes
Achievement Value	1.00

Report results of the Congestive Heart Failure measure to the State *(DY8-10)*

Data Collection Source	*	
Numerator	*	
Denominator	*	
Rate		

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

Achievement	N/A
Achievement Value	

Category 3: Care Coordination *(required)*

Report results of the Chronic Obstructive Pulmonary Disease measure to the State *(DY8-10)*

Data Collection Source *	
Numerator *	
Denominator *	
Rate	

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

Achievement	N/A
Achievement Value	

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/30/2012

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:	*	$ 3,861,000.00
Incentive Funding Already Received in DY:	*	$ 1,930,500.00

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

Data Collection Source	*	Electronic medical record (EMR)
Numerator	*	205.0
Denominator	*	325.0
Rate		63.1

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

03-31-2012:
Mid-Year reporting data sourced from a combination of reports and EMR chart abstraction. Obtained random sample of 325 patient charts from Fontana, McKee and Westside Family Health Centers for female patients of the specified age who had visited FHCs at least twice in DY6 (7/1/2010-6/30/2011), less defined exclusions; Patients meeting this population criteria that received mammograms during the reporting period (DY7 Mid-Year: between 7/1/2010 and 12/31/2011) counted toward the numerator. Continue data collection for year-end DY7 reporting.

09-30-2012:
Data Source: Data was sourced from Meditech reports. Due to the specific exclusion criteria and ARMC's current hybrid scanned/electronic medical record, it was necessary to sample the patient population in order to complete a manual review of each patient's electronic medical record. Sampling methodology was based upon specifications provided by SNI, which required a sample size of 325 patients for systems >1,000.

Improvements to Mammography Screening for Breast Cancer: As Family Health Clinics' electronic systems are enhanced and a means of more comprehensive data capture is attained, timely visibility to preventative patient care needs (as well as reporting exclusion criteria) should improve this population measure.

Any improvements to Category 3 population measures are based upon ARMC's ability to meet milestones outlined in Category 2 of the DSRIP plan. As ARMC progresses through the implementation of Category 2 initiatives, specifically:
• Development and management of the disease registry,
• Expansion of the Chronic Care model, and
• Patient Centered Medical home,
The expectation is that visibility and management of the female population who should receive mammography screening for Breast Cancer will increase, resulting in population measure improvement.

Achievement	Yes
Achievement Value	1.00

Category 3: Preventive Health *(required)*

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

Data Collection Source	*	Electronic medical record (EMR)
Numerator	*	1,710.0
Denominator	*	7,502.0
Rate		22.8

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):

03-31-2012:
Mid-Year reporting data sourced from ARMC billing reports. Patients receiving influenza vaccinations at sites outside of the ARMC DPH system were not counted in the numerator for this reporting period. Continue data collection for year-end DY7 reporting.

09-30-2012:
Data Source: Data was sourced from Meditech patient billing reports. There was a slight increase in the number of patients who received the influenza vaccination between the mid-year and year-end reporting periods, with 1710 patients receiving a vaccination.

Improvements to Influenza Immunization: ARMC continues to experience difficulty in efficiently tracking and reporting on patients who receive influenza vaccinations outside of the ARMC system (e.g., at area pharmacies, senior health fairs, etc.). However, as Family Health Clinics' electronic systems are enhanced and a means of more comprehensive data capture is attained, timely visibility to preventative patient care needs should improve this population measure.

These improvements will allow ARMC the capability to extract and report data that more accurately reflects the number of ARMC FHC patients receiving the influenza immunization during the flu season regardless of the patient's vaccination venue. As initiatives in Category 2, such as the implementation of the patient centered medical home progress, the expectation is that patient management will increase resulting in population measure improvement.

Achievement	Yes
Achievement Value	1.00

Report results of the Child Weight Screening measure to the State *(DY8-10)*

Data Collection Source	*	
Numerator	*	
Denominator	*	
Rate		

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

Achievement	N/A
Achievement Value	

Category 3: Preventive Health *(required)*

Report results of the Pediatrics Body Mass Index (BMI) measure to the State *(DY8-10)*

Data Collection Source	*
Numerator	*
Denominator	*
Rate	

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

Achievement	N/A
Achievement Value	

Report results of the Tobacco Cessation measure to the State *(DY8-10)*

Data Collection Source	*
Numerator	*
Denominator	*
Rate	

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

Achievement	N/A
Achievement Value	

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/30/2012

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:	*	$ 3,861,000.00
Incentive Funding Already Received in DY:	*	$ 1,930,500.00

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

Data Collection Source	*	Electronic medical record (EMR)
Numerator	*	111.0
Denominator	*	325.0
Rate		34.2

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

03-31-2012:
Mid-Year reporting data was sourced from a combination of MediTech Reports and EMR chart abstraction. Obtained random sample of 325 patient charts from Fontana, McKee and Westside Family Health Centers for adult diabetic patients who had visited FHCs at least twice in DY6 (7/1/2010-6/30/2011). Patients from this population with a LDL-C drawn during the reporting period (DY7 Mid-Year: between 7/1/2011 and 12/31/2011) and within control (<100 mg/dL) counted toward the numerator. Those patients without a draw during the mid-year DY7 timeframe did not receive credit in the numerator. Continue data collection for year-end DY7 reporting.

9-30-2012
Data Source: Data was sourced from a combination of Meditech reports and EMR chart abstraction. Enhancements to the HCIS report allowed for greater visibility to most recent lab dates and values resulting in a shortened time for manual review of sampled patient electronic medical records. Sampling methodology was based upon specifications provided by SNI, which required a sample size of 325 patients for systems >1,000. Approximately 1/3 of FHC Diabetic patients were recorded as having LDL-C <100.

Improvements to Diabetes Mellitus, LDL-C < 100 mg/dl: ARMC's ability to meet milestones outlined in Category 2 of ARMC DSRIP plan will allow the Family Health Clinics to improve Diabetic patients' LDL control by:
• Implementation the Disease Registry,
• Participation in the Safety Net Collaborative, and
• Expansion of the Chronic Care Model.
The expectation is that management of the Diabetic patient population will increase resulting in population measure improvement.

Achievement	Yes
Achievement Value	1.00

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

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

Data Collection Source	*	Electronic medical record (EMR)
Numerator	*	139.0
Denominator	*	325.0
Rate		42.8

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):

03-31-2012:
Mid-Year reporting data was sourced from a combination of MediTech Reports and EMR chart abstraction. Obtained random sample of 325 patient charts from Fontana, McKee and Westside Family Health Centers for adult diabetic patients who had visited FHCs at least twice in DY6 (7/1/2010-6/30/2011). Patients from this population with a HgbA1c drawn during the reporting period (DY7 Mid-Year: between 7/1/2011 and 12/31/2011) and within control (<9%) counted toward the numerator. Those patients without a draw during the mid-year DY7 timeframe did not receive credit in the numerator. Continue data collection for year-end DY7 reporting.

9-30-2012
Data Source: Data was sourced from a combination of Meditech Reports and EMR chart abstraction. Enhancements to NPR reports allowed for greater visibility to most recent lab dates and values resulting in a shortened time for manual review of sampled patient electronic medical records. Sampling methodology was based upon specifications provided by SNI, which required a sample size of 325 patients for systems >1,000.

On April 5, 2012 the California Healthcare Safety Net Institute (SNI) distributed an update to the HgbA1c measure, changing Control from <9% to <8%. 42.8% of FHC diabetic patients were recorded as having a Hemoglobin A1c Control <8%.

Improvements to Diabetes Mellitus, Hemoglobin A1c Control (<8%): ARMC's ability to meet milestones outlined in Category 2 of ARMC DSRIP plan will allow the Family Health Clinics to improve Diabetic patients' Hemoglobin A1c control by:
• Implementation the Disease Registry,
• Participation in the Safety Net Collaborative, and
• Expansion of the Chronic Care Model.
The expectation is that management of the Diabetic patient population will increase, resulting in population measure improvement.

Achievement	Yes
Achievement Value	1.00

Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State *(DY8-10)*

Data Collection Source	*	
Numerator	*	
Denominator	*	
Rate		

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

Achievement	N/A
Achievement Value	

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

Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State *(DY8-10)*

Data Collection Source *	
Numerator *	
Denominator *	
Rate	

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

Achievement	N/A
Achievement Value	

Report results of the Pediatrics Asthma Care measure to the State *(DY8-10)*

Data Collection Source *	
Numerator *	
Denominator *	
Rate	

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

Achievement	N/A
Achievement Value	

Report results of the Optimal Diabetes Care Composite to the State *(DY8-10)*

Data Collection Source *	
Numerator *	
Denominator *	
Rate	

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

Achievement	N/A
Achievement Value	

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

Report results of the Diabetes Composite to the State *(DY8-10)*

Data Collection Source *	
Numerator *	
Denominator *	
Rate	

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

Achievement	N/A
Achievement Value	

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR:
DATE OF SUBMISSION:

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

Below is the data reported for the DPH system.

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

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

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

Severe Sepsis Detection and Management

DY Total Computable Incentive Amount:	*	$ 2,178,000.00
Incentive Funding Already Received in DY:	*	$ 1,973,812.50

Compliance with Sepsis Resuscitation bundle (%)

Numerator	*	164
Denominator	*	362
% Compliance		0.45

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

03-31-2012:
Retrospectively screened 100% of all patient charts defined by SNI ICD-9 criteria for DY7 mid-year reporting period 7/1/2011-12/31/2011. Compliance with all four sepsis bundle (lactate, fluid administration, blood cultures and antibiotic administration) elements measured. Only those patients out of the severe sepsis and septic shock population complying appropriately with all four elements were given credit in the numerator. Sepsis Resuscitation bundle education formally rolled out beginning 12/16/2011. Presentation and competency saved to ARMC intranet. As of 12/31/2011, completion rate was 74%.

09-30-2012:
Retrospective sepsis screening for 100% of patient charts (as defined by ICD-9 criteria provided by SNI) was completed monthly. Compliance with all four sepsis bundle elements (lactate, fluid administration, blood cultures and antibiotic administration) was measured and reported to ARMC's Sepsis Committee, Nursing Executive Committee and other hospital services, units and committees.

Patients with severe sepsis and/or septic shock were counted in the numerator only if compliance was met on all four resuscitation bundle elements. For a more detailed description regarding ARMC's Severe Sepsis and Septic Shock Detection and Management related processes and data collection and reporting methodologies, please see *ARMC Sepsis Data Collection Methodology* document, submitted to the State on 06/22/2012.

Compliance with resuscitation bundle increased from an aggregate 39% (Q1 and Q2) to 50% (Q3 and Q4). Compliance rate for June 2012 was 58.6%.
ARMC initially reported 28% for the mid-year compliance rate submitted in March, but this number changed with the clarification of the compliance definition by the State and SNI; specifically in the areas of antibiotic requirements and fluid resuscitation, re-calculation of the retrospective data was based on the revised criteria.

ARMC developed solutions to the following challenges encountered during the implementation of the Sepsis resuscitation bundle as specified below:

Problem: Obtaining healthcare provider buy-in for lactate draws when a patient screens positive for possible sepsis.

Solution: As early detection and the early administration of appropriate therapy has been shown to dramatically improve patient outcomes, the ARMC Sepsis Committee agreed that lactate draws should occur when a patient screens positive for SIRS plus infection (sepsis). Initially, some healthcare providers were concerned to order or recommend laboratory tests that might be "unnecessary" or "premature" on patients without confirmed infection. Compliance in this area was 39% in the first quarter of DY7. Through ongoing education efforts, auditing, and sharing of best-practice literature and information, ARM was able to develop a better system-wide understanding of best practice guidlines and improve its rate of compliance on lactate draws to 56% in Quarter 4.

Problem: Administering adequate amounts of fluid for resuscitation (minimum 20mL/kg) upon presentation of severe sepsis or septic shock with low blood pressure or lactate greater than or equal to 4. This challenge resulted from differing criteria definitions. Until January 2012, ARMC was using a minimum of 1000 mL (1L) OR 20 ml/kg per patient (per the INLP definition) as the resuscitation bolus criteria. In January, SNI confirmed the minimum of 20 mL/kg to be the more rigorous and correct criteria to use.

Solution: ARMC began applying and educating to the updated criteria in January. However, Fluid resuscitation compliance rates still decreased slightly from 86% for Quarter 1 to 85% for Quarter 4. One reason that this area still remains a challenge is the question of how to appropriately fluid-resuscitate patients with co-morbidities that present fluid-overload challenges, such as end stage renal disease or congestive heart failure. Experts that ARMC contacted on sepsis listservs and those who have presented literature at SNI Sepsis/CLABSI collaborative meetings generally recommend to resuscitate with the SSC minimum guideline of 20 ml/kg (now 30 ml/kg per June 2012 revised guidelines) as the first priority and treat additional co-morbid-related side-effects as appropriate. Through daily concurrent audits and ongoing education and feedback, efforts to improve in the area of appropriate fluid resuscitation continue at ARMC. Efforts are currently focused in the Emergency Department (68% of ARMC's severely septic/septic shock population presented in ARMC's ED in DY7), and results have been positive.

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

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

Optional Milestone: 2) Hire 2 LVNs to assist with medical record review and data abstraction (shared amongst all 4 interventions)

(insert milestone)

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

03-31-2012:
Two LVNs were hired on 7/16/11. Unfortunately, neither individual was able to adequately fulfill the requirements of the position and both individuals were released (9/2/2011 and 10/5/2011, respectively). ARMC is currently in the process of interviewing candidates and has contracted with a 3rd party company long-term to assist with interim medical record review and data abstraction.

09-30-2012:
LVN hires released 9/2/2011 and 10/5/2011; hiring process re-initiated. Full-time LVN J. Minard was hired on 06/04/2012 with a start date of 07/14/2012. In the interim, contract clinicians B. Ramos and A. Gacad were hired to assist with DSRIP-related medical record review and data abstraction. A Gacad, LVN/medical coder is the primary data collection analyst for Severe Sepsis Detection and Management intervention. Ms. Gacad began her work as a contract member of ARMC Performance Improvement staff in November of 2011. Ms. Gacad has fulfilled a key role in this intervention; taking on additional duties of concurrent audits and information gathering and reporting. She is a member of the Sepsis Committee and the DSRIP team, and is a participating member of the SNI Sepsis and CLABSI Collaborative listserv. Ms. Gacad's knowledge of coding has been instrumental in the data collection and reporting process, leading to beneficial feedback shared with SNI on ICD-9 codes for reporting.

ARMC has experienced ongoing challenges with the time lag associated with the San Bernardino County Hiring process, which can often take up to 6 months just for position approvals and posting. As an interim solution, some departments within ARMC have employed the use of volunteer, alternate duty, and contract personnel, when applicable, to fill certain roles with positive results.

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

Optional Milestone: 3) Hire Staff Analyst to perform report writing data collection and analysis (shared amongst all 4 interventions)

(insert milestone)

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

03-31-2012:
Staff Analyst II, A. Beaven hired on 12/29/2011. Ms. Beaven is currently assisting with data collection and analysis, and is receiving ongoing training in MediTech report writing.

09-30-2012:
Staff Analyst II A. Beaven was hired on 12/29/2011 and began work with the Sepsis Committee in February, 2012. She currently assists with data collection and analysis of DSRIP Category 3 and 4 data and is the Co-Chair of the Patient Care System Core Team, a cross-disciplinary taskforce responsible for streamlining documentation interface, data collection and reporting associated with ARMC's HCIS. Ms. Beaven is a participating member of the Sepsis Committee and the SNI Sepsis and CLABSI Collaborative and works as part of the ARMC DSRIP team responsible for data gathering, analysis, validation and reporting for the Severe Sepsis and Septic Shock Detection and Management intervention. Ms. Beaven also participates in internal audits and feedback reporting for several DSRIP-Category 4-related initiatives, including Sepsis.

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

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

Optional Milestone: 4) Join the Surviving Sepsis Campaign to learn and share best practices related to improving severe sepsis and septic shock detection and management

(insert milestone)

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

03-31-2012:
Under a grant from the Gordon and Betty Moore Foundation, the Surviving Sepsis Campaign hosts a Surviving Sepsis Campaign listserve, an industry-free online forum where hospitals can discuss successes, seek assistance with challenges as bundles are implemented, ask clinical questions, share protocols and order sets and other topics of importance regarding sepsis, severe sepsis and septic shock. ARMC joined this listserve in July of 2011. Additionally, ARMC joined and participates in the SNI Sepsis and CLABSI Collaborative for the purpose of sharing information, best practices and challenges; participation includes data collection and submission, webinars and conference calls, a listserve with other participating DSRIP hospitals, and semi-annual learning sessions.

09-30-2012:
Per phone conversation with Lori Harmon at the Surviving Sepsis Campaign (SSC), July 2011, the portion of the international campaign involving hospital data collection was completed in 2010. The listserv community and current information are still active on the website, and ARMC has joined and utilized this listserv to gain information and to discuss challenges, ideas and best practice information with other institutions internationally who are focused on improving detection and management of patients with sepsis, severe sepsis and septic shock.

New 2012 Surviving Sepsis Guidelines were shared in June of 2012 and ARMC received an email that the SSC organization is currently revising the sepsis database tool to potentially begin collecting information once again. ARMC remains interested in receiving more information regarding this opportunity and potential participation in the future.

ARMC also currently participates in the Sepsis Collaborative with the Safety Net Institute. ARMC has consistently attended and participated in Collaborative events offered by SNI, including webinars, Learning Sessions, listserv, data submissions and requests for feedback and/or information on an ongoing basis. Through the Collaborative communications and listserv and the CAPH DSRIP web portal, ARMC has connected with other hospitals on the topic of Sepsis and shared questions, ideas and concerns regarding data collection, implementation challenges and successes and tools.

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

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

Optional Milestone: 5) Train clinical staff on Sepsis Bundle Element and Protocols, Checklists and Screening Tools (maintain on-going training education)
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	0.50
Denominator (if absolute number, enter "1")	*	1.00
Achievement		0.50
If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:	*	

03-31-2012:
Formal education and training on the sepsis resuscitation bundle elements and orders and forms began 12/16/2011. A sepsis presentation and competency evaluation has been posted to ARMC's intranet and is also covered during orientation and annual skills updates. Physician training is ongoing. Units are now being supplied with orders and screening forms, and initial sepsis screen is being built into MediTech. Roll-out for new forms is planned for March, 2012.

09-30-2012:
Sepsis Education Module developed and posted to ARMC intranet 12/16/2012; Education conducted in-house started 12/16/2011 and is ongoing.

Resident education was conducted by Dr. Huang , Internal Medicine, Sepsis Committee Chairman, January 2012; Dr. Lee, ED Physician, February, 2012; and Dr. Lanum, Family Medicine, February, 2012.

Ongoing Nursing education is provided at Nursing Orientation and Nursing Skills days. Training on sepsis screening methodology conducted beginning 12/16/2011 by Education department for Nursing, and is ongoing.

Nursing Leadership received additional sepsis education, including sepsis, severe sepsis and septic shock signs and symptoms, ARMC screening and resuscitation bundle tools and protocols on 03/28/2012 by ICU Nursing Educator, E. Sparling-Broccolo.

ARMC recognizes there is room for improvement in terms of system-wide sepsis education. Getting sepsis education materials to physician, nursing and ancillary staff efficiently and effectively presented an ongoing challenge for ARMC. Initially, uncertainty over definitions and requirements, time of presentation criteria, and how, where, when, and how often screening should occur delayed formal roll-out of education.

Streamlining the data collection process and initiating processes required focus of resources. Getting tools approved and printed rapidly created a lag between education on tools and actual availability of tools, ostensibly decreasing the overall effectiveness of the initial education. As ARMC ordering, documentation, and reporting technology becomes more robust, definitions become more concrete, and devoted resources, processes and equipment are established with the appropriate training and development, there is anticipation that a more comprehensive education effort can be fleshed out and applied for DY8 with positive results.

Movement away from a traditional formal build-up-roll-out process to the IHI small tests of change model is also a methodology that could shorten implementation times and provide immediate feedback that is valuable for rapid and successful implementations.

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

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

Optional Milestone: 6) Develop Intensive Care Unit policies and procedures to support compliance with the Sepsis Resuscitation Bundle
(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

03-31-2012:
A general sepsis nursing policy was approved by ARMC's Quality Medical Committee and Medical Executive Committees in December, 2011. Future need for unit-specific (such as ICU) policies will be evaluated by Nursing and Education and will be addressed as needed.

09-30-2012:
ARMC's Sepsis Nursing policy was initially developed in July 2011 and revised, with final approval occurring in December 2011. There are currently no ICU-specific policies at this time; however, there are unit-specific algorithms for the ongoing screening and code sepsis protocol for ICU, Telemetry and Med-Surg, Maternal-child, Orthopedics, and the Emergency Department. Policy review, revision, and development will occur as necessary by Nursing and Education.

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

Achievement Value: 1.00

Optional Milestone: 7) Implement the Sepsis Resuscitation Bundle
(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

03-31-2012:
Formal implementation for sepsis occurred following initial baseline data collection, 12/16/11. Education and training is ongoing.

09-30-2012:
In July 2011, ARMC re-vitalized its Sepsis Committee, recruiting a new Chairman, a renewed focus and a cross-disciplinary team for membership. Attendees include:
- Infectious Disease/Internal Medicine Physician (Chairman),
- Family Medicine Physician, Assistant Nurse Manager and Nurse Educator
- Emergency Department Physician,
- Surgery Physician,
- Nursing Education,
- ICU and Burn Nurse Managers,
- Pharmacist,
- Respiratory Therapy,
- Quality Staff Analyst II,
- Performance Improvement Nurses, and
- Laboratory.

This Medical Staff Committee meets in its entirety at minimum, once per month to discuss data and performance fallouts and issues, tools and education status updates, ideas gleaned from the listservs/Collaborative/other resources and any issues or information regarding new developments or best practice. Reports are presented monthly to the Nurse Executive Committee and quarterly to the Medical Staff Quality Management Committee.

Education was initiated in December 2011; roll out of forms January 2012. Screening for inpatient units began on 04/18/2012. ED rounding by QAPI staff was in planning stages in June 2012 for implementation in July 2012. As of 06/30/2012, screening for all adult ED patients roll out is pending triage form revision to include sepsis screening tool and

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

Achievement Value: 1.00

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

Optional Milestone: 8) 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: 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

03-31-2012:
Data for 6/1/2011-11/30/2011 was submitted to SNI on 12/16/2011. Final receipt confirmation was provided on 12/29/2011. Numerator: 38 Denominator: 155 Rate: 24.5% compliance with all four measures for ARMC, data period: June 1, 2011-November 30, 2011.

09-30-2012:
Completed and submitted to DHCS and CAPH 03/2012.

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

Achievement Value: 1.00

Optional Milestone:
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Optional Milestone:
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

Optional Milestone:
(insert milestone)

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

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

Achievement: N/A

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

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

Achievement Value

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/30/2012

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:	*	$ 2,178,000.00
Incentive Funding Already Received in DY:	*	$ 2,069,100.00
Compliance with Central Line Insertion Practices (CLIP) (%)		
Numerator	*	109.00
Denominator	*	124.00
% Compliance		0.88

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):

03-31-2012:
Submission for ARMC DY7 Mid Year reporting period 7/1/2011-12/31/2011; continue data collection for DY7 Year end reporting.

09-30-2012:
Data for 07/01/2011-06/30/2012 will be reported to the State by 09/30/2012.

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

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

Optional Milestone: 21) Train clinical staff to document line day during rounds as part of daily goal sheets

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	0.75
Denominator (if absolute number, enter "1")	*	1.00
Achievement		0.75
If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:	*	No

03-31-2012:
Although central line bundle (including CLIP compliance, removal of trauma line within 24 hours, Central Line Procedure Note and Dressing Change guidelines) documentation continues on daily goal sheets within the ICUs, ARMC improved the efficiency of the line-day documentation process by moving to electronic spreadsheets for units hospital-wide.

09-30-2012:
Although device assessment and care is documented in the HCIS by Nursing each shift, as well as on ICU daily goal sheets, ongoing documentation of patient device days and efficient extraction of this data has traditionally been a challenge for ARMC.

At ARMC, Infection Control/Epidemiology is responsible for the tracking, analysis, and reporting of all Healthcare Acquired Infection (HAI) data. With increased focus on HAI reporting it became clear that the data collection methodology required improvement.

In July and August of 2011, Infection Control Nurses educated unit champions (often charge nurses or unit clerks) on how to consistently and properly document central line days on excel spreadsheets for each patient. These spreadsheets, in turn, were monitored by Infection Control staff on an ongoing basis. This resulted in a more efficient and accurate capture of device days in each area.

In October 2011, ARMC voluntarily took part in a 3rd-party validation of Central Line data collection to ensure data collection, analysis and reporting methodologies were returning accurate and reliable information. The conclusion of the validating body, CDPH, was that ARMC was adequately assessing and reporting its central line associated bloodstream infections.

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

Optional Milestone: 22) Hire Staff Analyst to perform report writing, data collection and analysis (shared amongst all 4 interventions)

(insert milestone)

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

03-31-2012:
Staff Analyst II, A. Beaven hired on 12/29/2011. Ms. Beaven is currently assisting with data collection and analysis, and is receiving ongoing training in MediTech report writing.

09-30-2012:
Staff Analyst A. Beaven hired 12/29/2011, began work with the CLABSI prevention Task Force in February, 2012. Ms. Beaven currently assists with data collection and analysis of DSRIP Category 3 and 4 data and is the Co-Chair of the Patient Care System Core Team, a taskforce responsible for streamlining documentation, data collection and reporting at ARMC. Ms. Beaven is a participating member of the CLABSI Prevention Task Force and CLABSI Lean Mapping Team, as well as the SNI Sepsis and CLABSI Collaborative. Ms. Beaven works as part of the ARMC DSRIP team responsible for Line Necessity audits and reporting, as well as internal summarizing of CLIP performance from NHSN data. Her work with the CLABSI Lean Mapping Team has included gathering input and completing revisions to ARMC's CLIP form and interviewing practitioners regarding recommended contents and use of the Central Line Carts and potential issues with central line insertion.

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

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

Optional Milestone: 23) Hire 2 LVNs to assist with medical record review and data abstraction (shared amongst all 4 interventions)

(insert milestone)

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

03-31-2012:
Two LVNs were hired on 7/16/11. Unfortunately, neither individual was able to adequately fulfill the requirements of the position and both individuals were released (9/2/2011 and 10/5/2011, respectively). ARMC is currently in the process of interviewing candidates and has contracted with a 3rd party company long-term to assist with interim medical record review and data abstraction.

09-30-2012:
LVN hires released 9/2/2011 and 10/5/2011; hiring process re-initiated. Full-time LVN J. Minard was hired on 06/04/2012 with a start date of 07/14/2012. In the interim, contract clinicians B. Ramos and A. Gacad were hired to assist with DSRIP-related medical record review and data abstraction. A Gacad, LVN/medical coder is the primary data collection analyst for Severe Sepsis Detection and Management intervention, but also collects additional data for category 3 and 4 initiatives, such as Line Necessity audits. Ms. Gacad began her work as a contract member of ARMC Performance Improvement staff in November 2011. Although primary data collection and reporting duties for CLABSI prevention fall on Infection Control/Epidemiology, Ms. Gacad works closely with this team and other PI/Quality staff to ensure reporting is completed for Collaborative and DSRIP deadlines.

ARMC has experienced ongoing challenges with the time lag associated with the San Bernardino County Hiring process, which can take up to 6 months for position approvals and posting. As an interim solution, some departments within ARMC have employed the use of volunteer, alternate duty, and contract personnel, when applicable, to temporarily fill roles with positive results.

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

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

Optional Milestone: 24) Train clinical staff on the Central Line Bundle (maintain on-going training education)

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	0.50
Denominator (if absolute number, enter "1")	*	1.00
Achievement		0.50
If "yes/no" as to whether the milestone has been achieved, 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

03-31-2012:
Ongoing training occurs during orientations, unit-specific skills training and informal in servicing updates. Hand hygiene audits ongoing; online competencies for hand hygiene 09/01/2011 and 12/27/2011.

09-30-2012:
ARMC incorporates 4 of the 5 components of the Institute for Healthcare Improvement's (IHI) Central Line Bundle into its Central Line Insertion Practices (CLIP) form, including:
• Hand hygiene,
• Maximal barrier precautions upon insertion,
• Chlorhexidine skin antisepsis, and
• Optimal catheter site selection, with avoidance of using the femoral vein for central venous access in adult patients
ARMC's CLIP form is a checklist used in the preparation of and during each central line insertion to remind providers of important infection prevention practices. IHI's fifth prevention component, daily line necessity review, is part of ongoing care and management for central lines.

Training of clinical staff on the central line bundle elements occurs during nursing orientation and through presentation boards presented at annual skills days at ARMC.

Physician training on central line insertion and the central line bundle occurs during service rotations and as an educational requirement for competency.

Despite ongoing training, ARMC continues to experience CLABSI rates significantly higher than the national average. ARMC continues to evaluate and focus on revising current practice to eliminate the system failures propagating infection. Strategies include:
• Formation of a CLABSI Task force, including membership from
o Surgery Department (Chairman),
o Infection Control team,
o Performance Improvement and
o Quality Nurses and Staff Analyst,
o ICU and Burn Nurse Managers,
o NICU Nurse Manager,
o Med-Surg Nurse Managers/Assistant Nurse Managers,
o PICC Line Nurse,
o Chief Nursing Officer, and
o Nursing Education.
• CLABSI Lean Mapping team focused on:
o Construction/implementation of central line carts
o Development/trialing of a more comprehensive CLIP form including pre, during and post insertion activities
o Investigation into use/effectiveness and trialing of alcohol infused caps (CUROS) as an additional infection prevention measure in the care and maintenance of central lines
o Requiring observers to be present during line insertions for the completion of CLIP forms and to provide assistance to inserter as needed within the confines of scope of practice
• Increasing hand hygiene audits and reporting.
Preparations, approvals and requisitions for these interventions have been made. Expected implementation will occur throughout the first six months of DY8. ARMC recognizes the benefits of rapid tests of change and the IHI Plan-Do-Study-

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

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

Optional Milestone: 25) Obtain a baseline on: (1) compliance with optimal catheter site selection, with avoidance of using the femoral vein for central venous access in adult patients and (2) evidence of daily review of line necessity with prompt removal unnecessary lines

(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

03-31-2012:
Baseline obtained on compliance for optimal catheter site selection with CLIP data (98%); line necessity review validation process occurs once per month. For the last Wednesday of each month, 100% of all charts for patients with central lines are audited for Physician documentation of central line necessity. Rate for DY7 mid year reporting period (7/1/2011-12/31/2011): 17/201, or 8%. ARMC is currently developing it's reporting and distribution process for this data and a plan to increase documentation compliance (including pre-printed progress notes, education and service/attending level reporting).

09-30-2012:
Compliance with optimal catheter site selection and daily review of line necessity with prompt removal of lines are each components of the central line bundle. To obtain a baseline on performance, ARMC collected data on each of these criteria in DY 7. Results were as follows:

1) Catheter site selection with avoidance of femoral line:
18 femoral lines placed out of 520 total central lines in DY 7
- 3.5% of lines placed were femoral lines, or
- Compliance rate = 96.5%

ARMC's CLIP form requires a reason be documented when inserting a femoral line. The primary justification provided by Physicians, is trauma or necessity for emergent line.

2) Daily review of Line Necessity:
Physician Progress notes were reviewed for: 1) documentation of central line and 2) rationale for continuance. To be considered compliant, physician documentation had to include both items.
- 53/376 charts audited contained complete documentation
- Compliance rate was 14%

Improvement is clearly needed in the area of central-line related documentation. Identified areas of focus for improvement on this milestone in DY8 include:
- Specification on revised CLIP form of the subclavian site as the preferred insertion site (with the exception of PICC lines)
- Specified reasons with checkboxes for femoral insertions
- Revision and standardization of physician progress notes to include area specific to central line necessity and documentation

ARMC is moving towards more consistent and immediate feedback and follow-up on any documentation found to be incomplete during the monthly line necessity auditing process

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

Achievement Value: 1.00

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

Optional Milestone: 26) Implement the Central Line Insertion Practices (CLIP)
(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

03-31-2012:
CLIP compliance on the ICUs was in practice at ARMC prior to 7/1/2011 and was implemented house-wide in August 2011.

09-30-2012:
Prior to the beginning of DY7, ARMC was consistently utilizing the Central Line Insertion Practices (CLIP) as defined by the CDC in its NICU, SICU, MICU and Burn units. With increased national emphasis and awareness on reducing HAIs, ARMC standardized CLIP Form use house-wide in August 2011. At ARMC the CLIP Form is a standard part of the patient medical record.

In an effort to increase reliability of Central Line Insertion practices and reduce central line infections, in December 2011, the Infection Control Committee presented a letter to the Quallity Management Committee (QMC) recommending that ARMC adopt a policy mandating an observer be present at bedside during insertion and complete the CLIP form. QMC, the Medical Executive Committee (MEC), and the Nursing Executive Committee (NEC) agreed and approved the recommendation.

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

Optional Milestone: 27) Report at least 6 months of data collection on CLIP to SNI for purposes of establishing the baseline and setting benchmarks
(insert milestone)

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

03-31-2012:
Data for 6/1/2011-11/30/2011 was submitted to SNI on 12/16/2011. NHSN rights were also conferred to SNI. Final receipt confirmation was provided on 12/29/2011.

09-30-2012:
NHSN data viewing rights were conferred to SNI upon request and electronic data was submitted to SNI 12/16/2011.

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

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

Optional Milestone: 28) Report at least 6 months of data collection on CLABSI to SNI for purposes of establishing the baseline and setting benchmarks

(insert milestone)

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

03-31-2012:
Data for 6/1/2011-11/30/2011 was submitted to SNI on 12/16/2011. NHSN rights were also conferred to SNI. Final receipt confirmation was provided on 12/29/2011.

09-30-2012:
NHSN data viewing rights were conferred to SNI upon request and electronic data was submitted to SNI 12/16/2011.

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

Optional Milestone: _____

(insert milestone)

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

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

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/30/2012

Category 4: Hospital-Acquired Pressure Ulcer Prevention

REPORTING ON THIS PROJECT: * Yes

Below is the data reported for the DPH system.

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

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

Category 4: Hospital-Acquired Pressure Ulcer Prevention

Hospital-Acquired Pressure Ulcer Prevention

DY Total Computable Incentive Amount:	*	$ 2,178,000.00
Incentive Funding Already Received in DY:	*	$ 1,754,500.00

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

Numerator	*	131.00
Denominator	*	2,604.00
Prevalence (%)		0.05

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):

03-31-2012:
ARMC data collected for DY7 mid-year reporting period (07/01/2011-03-31-2012): ARMC data collected for DY7 mid-year reporting period (07/01/2011-12/31/2011) per CALNOC/SNI specifications. Numbers include prevalence of Stage II, III, IV or unstageable pressure ulcers (per patient) documented, regardless of whether present on admission or hospital acquired. Hospital acquired prevalence rate for the same time period is 8/225, or 4%

09-30-2012:
DATA COLLECTION METHODOLOGY
Using the CALNOC methodology outlined by CAPH/SNI in the manual, Category 4 -- *Urgent Improvement in Quality and Safety Technical Specifications and Data Collection Methods* , monthly assessments are conducted to capture number of patients with hospital acquired and present-on-admission pressure ulcers.

ARMC Wound Resource Nurses conduct the assessments on the last Wednesday of each month. During these monthly studies, WRN assess the patients, review documentation, and calculate patient risk to identify any additional pressure ulcer prevention measures needed. These nurses also serve as teaching resources for unit colleagues. The CWOCN and Wound Care Nurse are consulted as needed for patients requiring a higher level of evaluation.

DATA REPORTING
Results of monthly WRN Prevalence and Incidence assessments are submitted to F. Dyckman and S. Culp for review and calculation. Pressure ulcer rates are tracked and reported internally on a monthly basis to the following Committees:
• Wound and Skin,
• Patient Safety (recently switched to quarterly)
• Nurse Executive, and
• Quality Management (quarterly).

For the 03/31/2012 submission, in accordance with CALNOC methodology, 1 assessment was provided for reporting out of the 6 month period. Originally, October was selected as the reporting rate with a HAPU rate of 8/225 patients or 3.6%. After clarifying HAPU reporting methodology with SNI, ARMC discovered that an aggregate should have been submitted instead:

- Data was reviewed once again. At this time, a monthly point HAPU incidence aggregate was calculated for a mid-year performance rate of 4.4% (55/1247). This included 6 monthly surveys from the time period of 07/01/2011-12/31/2011.
- Twelve month aggregate HAPU rate was also calculated for total DY7 performance at 5.0% (131/2604); the increase in aggregate for the 2nd half of DY7 was attributed to 7 patients with HAPUs who remained hospitalized over several months.
- ARMC will be reporting aggregate rates moving forward for all DSRIP HAPU data submissions per the clarification.

WOUND AND SKIN COMMITTEE
The Wound and Skin Committee began meeting monthly 11/15/2011 to collaborate on the pressure ulcer prevention bundle and the prevention of hospital acquired pressure ulcers. The Wound and Skin Committee is a subcommittee of the Patient Safety Committee. Physician Champion is Dr. J. Davis and Nurse Champion is F. Dyckman.

F. Dyckman organizes and chairs the meetings. Cross-disciplinary membership includes representatives from:
• Dept. of Surgery,

Category 4: Hospital-Acquired Pressure Ulcer Prevention

• Wound and Skin,
• Education,
• Nursing/Nurse Management,
• Respiratory,
• Rehabilitation Services Wound Care Clinic and Physical Therapy, and
• Performance Improvement.
Beginning January 2012, sub-groups from the Committee worked to develop unit specific pressure ulcer prevention protocols for the ED ("Walk and Roll") and ICU ("The Birds and the Bs"); additionally, specific bundle elements are also being explored in the Surgery/Recovery areas.

UNIT SPECIFIC BUNDLES
Pressure Ulcer Prevention Bundles implemented at ARMC include:
• Walk and Roll and the 4 Bs
- Specific protocols for the Emergency Department
- Nurses either walk or roll the pateint
- Address the 4 B's (Bed, Butt, Boots, Back of head)
The Birds and the Bs
- Specific protocols for the ICU
-Birds (Braden plus Intubation, Restraints and Restrictions, and Decomposing Signs)
- Address the 4 B's as described above

OR/PACU measures: application of sacral patches prior to surgery, attention to surgery specific positioning for pressure off loading, and ICU hand off reporting.

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

Category 4: Hospital-Acquired Pressure Ulcer Prevention

Optional Milestone: 42) Train physicians, residents, nursing staff and allied health professionals on the Pressure Ulcer Prevention Bundle (maintain on-going training education)

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	0.75
Denominator (if absolute number, enter "1")	*	1.00
Achievement		0.75
If "yes/no" as to whether the milestone has been achieved, 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

03-31-2012:

Training for staff is ongoing. Trainings occur at orientations and annual skills updates for Nursing. Physician training was held on 12/22/2011 by F. Dyckman, CWOCN and DPTs S. Swen and J. Edwards. Formal education and training on the Pressure Ulcer Prevention Initiative Care Bundle began as an embedded module of Nursing Skills Day, New Nurse Orientation and Unit Specific Skills Day starting in January 2011. Additional training for unit-based Wound Resource Nurses occurs on a monthly basis (at a minimum), led by F. Dyckman. Monthly Wound Resource Nurse educational activities have included: Use and trouble shooting of support surfaces, use and application of prevention skin care treatments, Treatment algorithms and use of enzymatic debridement agents, pressure ulcer causes, prevention and treatment, legal Implications and documentation standards, and National Institute for Nursing Quality Indicator Pressure Ulcer training online.

09-30-2012:

NURSING AND ANCILLARY TRAINING
ARMC training on the Pressure Ulcer Prevention Bundle was conducted for each skills day, orientation and unit-skills day for Nurses and Ancillary staff. Additional training included:
• Respiratory Therapy staff meeting on 3/8/2012
• Rehab staff meeting on 3/20/2012
• OR education on 4/4/2012

WOUND RESOURCE NURSE TRAINING
ARMC implemented Wound Resource Nurses (WRN) Champions on all adult units prior to 2011 in an effort to effectively and efficiently disseminate information and education on best practices concerning wound care throughout the hospital. Training on methods, equipment, devices, protocols and tools to preserve skin integrity, prevent pressure ulcers, assess individual patient risk and effectively deliver all aspects of the pressure ulcer prevention bundle was conducted for WRN on a monthly basis.

In addition, advanced training on etiology, recognition, staging and treatment took place on 3/13/2012 and 3/14/2012; and on an on-going basis for new Wound Resource Nurses.

PHYSICIAN AND RESIDENT TRAINING
Physician and Resident training for Pressure Ulcer Prevention included a resident Lunch and Learn on 3/15/2012.

Efficient dissemination of information and training to collective Medical Staff and Residents is an area that presents an opportunity for positive change and development at ARMC. Education provided to physicians and residents on HAPU prevention included scheduled lunch and learn and reference materials. In addition, ARMC is exploring a more streamlined methodology for distributing educational materials to Medical Staff moving forward

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

Category 4: Hospital-Acquired Pressure Ulcer Prevention

Optional Milestone: 43) Hire Staff Analyst to perform report writing data collection and analysis (shared amongst all 4 interventions

(insert milestone)

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

03-31-2012:
Staff Analyst II, A. Beaven hired on 12/29/2011. Ms. Beaven is currently assisting with data collection and analysis, and is receiving ongoing training in MediTech report writing.

09-30-2012:
Staff Analyst II, A. Beaven hired 12/29/2011; start date of 01/30/2012. Ms. Beaven assists with data collection and analysis of DSRIP Category 3 and 4 data and is the Co-Chair of the Patient Care System Core Team, a taskforce responsible for streamlining documentation, data collection and reporting at ARMC. Ms. Beaven attends monthly Wound and Skin HAPU Prevention Committee meetings and completes monthly rounding audits and weekly patient turning audits in support of the HAPU prevention intervention.

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

Optional Milestone: 44) Hire 2 LVNs to assist with medical record review and data abstraction (shared amongst all 4 interventions)

(insert milestone)

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

03-31-2012:
Two LVNs were hired on 7/16/11. Unfortunately, neither individual was able to adequately fulfill the requirements of the position and both individuals were released (9/2/2011 and 10/5/2011, respectively). ARMC is currently in the process of interviewing candidates and has contracted with a 3rd party company long-term to assist with interim medical record review and data abstraction.

09-30-2012:
LVN hires released 9/2/2011 and 10/5/2011; hiring process re-initiated. In the interim, contract clinicians B. Ramos and A. Gacad were hired to assist with DSRIP-related medical record review and data abstraction. F. Dyckman and S. Culp and the Wound Resource Nurses currently share the primary responsibility of chart reviews for data collection. In conjunction with Staff Analyst II, A. Beaven, A. Gacad attends the monthly Wound and Skin HAPU Prevention Committee meetings and periodically assists with data compilation and auditing for the HAPU prevention intervention.

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

Category 4: Hospital-Acquired Pressure Ulcer Prevention

Optional Milestone: 45) Establish pressure ulcer baseline data
(insert milestone)

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

03-31-2012:
Six months of data (7/1/2011-12/31/2011) was collected as a baseline for DSRIP project.

09-30-2012:
Completed establishment of baseline data and submitted to SNI 12/16/2011. A HAPU prevalence rate of 3.6% was reported for the first 6 months from the October assessment as baseline, however, per clarification from SNI, the aggregate rate of 5.0% for all 12 months will be utilized as ARMC baseline for HAPU DSRIP reports.

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

Optional Milestone: 46) Implement hourly rounding by nursing staff in all adult inpatient units
(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

03-31-2012:
Hourly rounding was implemented as a customer service improvement initiative in September of 2011. This practice addresses Clinician/Patient/Patient Family interaction and impacts wound and skin care/pressure ulcer prevention by addressing the "4 P's" interventions during each hourly interaction: Pain, Pressure, Potty and Positioning of items in the room for easy patient access and safety.

09-30-2012:
Hourly rounding was implemented hospital-wide in September 2011 as part of a customer service improvement initiative. This practice addresses Clinician/Patient /Family interaction and impacts wound and skin care/pressure ulcer prevention by addressing the "4 P's" (Pain, Pressure, Potty and Position) during each hourly interaction. Additional supportive efforts for hourly rounding at ARMC include:
- Studer and AIDET Training
- Nurse Manager Leadership rounds and audits
- Hourly rounding audits initiated by QAPI staff with immediate feedback on units and overall performance reported monthly to Nurse Executive Committee

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

Category 4: Hospital-Acquired Pressure Ulcer Prevention

Optional Milestone: 47) Join Cal-Noc to report Pressure Ulcer Incidence and Prevalence
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	0.75
Denominator (if absolute number, enter "1")	*	1.00
Achievement		0.75
If "yes/no" as to whether the milestone has been achieved, 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

03-31-2012:
ARMC signed a contract with CALNOC as a California Hospital Assessment and Reporting Taskforce (CHART) level hospital in 2011. On 12/19/2011, CHART released a statement that their Board of Directors was taking the organization in a different direction and data would no longer be required to be submitted by member hospitals, effective immediately. Shortly after, CALNOC followed up with an email confirming that CHART level hospitals could elect to become full members of CALNOC, and that no further data would be required or accepted for the CHART project. ARMC was therefore unable to submit it's Q4 2011 data to CALNOC prior to the change. ARMC is currently in the process of pursuing full CALNOC membership to report future Pressure Ulcer related data.

09-30-2012:
CALNOC CHART member until January 2012; data collected monthly per CALNOC guidelines from September 2011 forward. On March 12, 2012 ARMC contacted CALNOC to pursue full membership. CNO, Dr. M. Sayre began taking steps to finalize CALNOC agreement as ARMC Site Coordinator in the last quarter of DY7. F. Dyckman, CWOCN and ARMC Skin and Wound Coordinator and B. Terrell, Nurse Manager, 3 Center and Champion for other Nurse Sensitive indicators attended CALNOC Symposium 6/12/2012 – 6/15/2012. As of 06/30/2012, ARMC is awaiting final contract signatures and payment to CALNOC for membership.

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

Optional Milestone: 48) Share data, promising practices, and findings with SNI to foster shared learning and benchmarking across the California public hospitals
(insert milestone)

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

03-31-2012:
On 12/30/2011, data, promising practices and findings related to ARMC's Pressure Ulcer Prevention Initiative (PUPI) and HAPU prevention were submitted to SNI for the purpose of fostering shared learning and benchmarking across the California public hospitals. The Wound and Skin DSRIP Committee, which is a functional subcommittee of Patient Safety, was revitalized in 2011 and began earnestly evaluating HAPUs as interdisciplinary case studies. The committee currently has developed a unit specific Pressure Ulcer Care Bundle for the Emergency Department, which is nurse care centered. This Care Bundle will be formally rolled out in first quarter 2012. In addition, the committee has a task force evaluating the need for an ICU specific Risk Evaluation Tool, beyond the limits of the currently used Braden Scale, and is in the process of developing an interdisciplinary Pressure Ulcer Prevention Care Bundle for ICU patients.
Educational plans include:
Validated Competency Training based upon National Pressure Ulcer Advisory Panel recommendations for all Wound Resource Nurses to ensure validity of all Prevalence data collected.

09-30-2012:
Submitted data to SNI 12/22/2011

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

Category 4: Hospital-Acquired Pressure Ulcer Prevention

Optional Milestone: ______________________________
(insert milestone)

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

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

Achievement N/A

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

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

Achievement Value

Optional Milestone: ______________________________
(insert milestone)

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

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

Achievement N/A

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

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

Achievement Value

Optional Milestone: ______________________________
(insert milestone)

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

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

Achievement N/A

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

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

Achievement Value

Category 4: Hospital-Acquired Pressure Ulcer Prevention

Optional Milestone: ____________________
(insert milestone)

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

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

Achievement N/A

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

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

Achievement Value

Optional Milestone: ____________________
(insert milestone)

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

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

Achievement N/A

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

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

Achievement Value

Optional Milestone: ____________________
(insert milestone)

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

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

Achievement N/A

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

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

Achievement Value

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP
DPH SYSTEM: Arrowhead Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/30/2012

Category 4: Stroke Management

REPORTING ON THIS PROJECT: * Yes

Below is the data reported for the DPH system.

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

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

Stroke Management

DY Total Computable Incentive Amount: * $ 2,178,000.00

Incentive Funding Already Received in DY: * $ 2,178,000.00

Optional Milestone: 61) Hire Staff Analyst to perform report writing data collection and analysis (shared amongst all 4 interventions)
(insert milestone)

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

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

Achievement: Yes

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

03-31-2012:
Staff Analyst II, A. Beaven hired on 12/29/2011. Ms. Beaven is currently assisting with data collection and analysis, and is receiving ongoing training in MediTech report writing.

09-30-2012:
Staff Analyst II, A. Beaven hired 12/29/2011; start date of 01/30/2012. Ms. Beaven currently assists with data collection and analysis of DSRIP Category 3 and 4 data and is the Co-Chair of the Patient Care System Core Team, a taskforce responsible for streamlining documentation, data collection and reporting at ARMC. Ms. Beaven attends Stroke Committee meetings as a member of the PI DSRIP team, and facilitates with compiling stroke data for DSRIP reporting.

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

Achievement Value: 1.00

Optional Milestone: 62) Hire 2 LVNs to assist with medical record review and data abstraction (shared amongst all 4 interventions)
(insert milestone)

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

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

Achievement: Yes

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

03-31-2012:
Two LVNs were hired on 7/16/11. Unfortunately, neither individual was able to adequately fulfill the requirements of the position and both individuals were released (9/2/2011 and 10/5/2011, respectively). ARMC is currently in the process of interviewing candidates and has contracted with a 3rd party company long-term to assist with interim medical record review and data abstraction.

09-30-2012:
LVN hires released 9/2/2011 and 10/5/2011; hiring process was re-initiated. In the interim, contract clinicians B. Ramos and A. Gacad hired to assist with DSRIP-related medical record review and data abstraction. Ms. Ramos, (a Physician by training/pending board certification in the United States) retrospectively abstracts charts of stroke patients using CMS specifications and prepares reporting for the ARMC Stroke Committee and internal information distribution.
06/04/2012--Full-time LVN J. Minard hired, with start date of 07/14/2012. Ms. Minard will be responsible for stroke abstraction in DY8, following completion of training.

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

Achievement Value: 1.00

Category 4: Stroke Management

Optional Milestone: 63) Report at least 6 months of data collection on the 7 stroke management process measures to SNI for purposes of establishing the baseline and setting benchmarks

(insert milestone)

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

03-31-2012:
Data for 6/1/2011-11/30/2011 was submitted to SNI on 12/16/2011. Final receipt confirmation was provided on 12/29/2011.
Stroke Indicators are as follows: STK-2 = 86/86= 100%; STK-3 = 5/5 = 100%; STK-4 Thrombolytic Therapy = 3/3 = 100%; STK-5 Antithrombotic Therapy by End of Day 2 = 90/90 = 100%; STK-6 Discharged on Statin Medication = 86/86 = 100%; STK-8 Stroke Education = 95/119 = 80%; STK-10 Assessed for Rehabilitation prior = 115/125 = 92%

09-30-2012:
Milestone completed Mid-Year DY7. Data was submitted to SNI 12/16/2011. Reference 03/31/2012 reporting above for performance specifics.

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

Category 4: Stroke Management

Optional Milestone: 64) Report the data to the State

(insert milestone)

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

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

Achievement: Yes

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

03-31-2012:
Reflects compliance with collecting and submitting 7 stroke measures to the State for DY7 mid-year reporting period (7/1/2011-12/31/2011). Continue to collect data for DY7 year end reporting period. Stroke Indicator values for this reporting period are as follows: STK-2 = 83/83 = 100%; STK-3 = 7/7 = 100%; STK-4 Thrombolytic Therapy = 4/4 = 100%; STK-5 Antithrombotic Therapy by End of Day 2 = 90/90 = 100%; STK-6 Discharged on Statin Medication = 86/86 = 100%; STK-8 Stroke Education = 95/126 = 100%; STK-10 Assessed for Rehabilitation prior = 119/127 = 94%

09-30-2012:
Data obtained from ARMC HCIS.
Stroke indicator values for reporting period 07/01/2011-06/30/2012 are as follows:

STK-2 Antithrombotic Therapy at discharge = 220/228 = 96%
STK-3 A-fib/flutter patients on anticoagulants at discharge: 18/21 = 86%
STK-4 Thrombolytic Therapy = 12/23 = 52%
STK-5 Antithrombotic Therapy by End of Day 2 = 244/249= 98%
STK-6 Discharged on Statin Medication = 232/237 = 98%
STK-8 Stroke Education = 280/337 = 83%
STK-10 Assessed for Rehabilitation prior = 328/343 = 96%

Compliance rates decreased in the third quarter of DY7; resulting in part from an increased number of stroke patients arriving to ARMC beginning January, 2012. ARMC has designated Stroke units with Stroke certified Nursing staff. Due to the increase of stroke patients admitted to the hospital, patients and resources were distributed throughout the facility based upon census and bed availability.

In response to the increase in stroke patients, ARMC expanded resources and training to staff by taking the following steps:
- Official allocation of Unit 6 South as Stroke Center overflow unit, with appropriate certification of nursing resources on this unit
- Broad dissemination of training and education house-wide, with certification of nurses in ED, ICUs, 4 North and 6 South

Stroke intervention-related dates, meetings, events:
- ARMC Stroke Committee meets, at minimum, monthly. The Committee is chaired by D. Miulli, DO, Neurosurgery; Cross-disciplinary team includes Nursing/Nurse Managers, Education, Neurosurgery, Neurology, Rehabilitation Services, Emergency Services, Laboratory, Radiology, Nursing and Operations Administrators, and Palliative Care.
- HFAP Stroke Re-certification survey in May 2012; renewed in July 2012
- Interim Stroke Coordinator started 6/15/12
- Stroke Grand Rounds: 08/04/2011, 12/15/2011, 02/23/2012
- Stroke Summit 11/04/2011

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

Achievement Value: 1.00

Category 4: Stroke Management

Optional Milestone: _____

(insert milestone)

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

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

Achievement N/A

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

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

Achievement Value

Optional Milestone: _____

(insert milestone)

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

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

Achievement N/A

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

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

Achievement Value