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:	Kern Medical Center
* REPORTING YEAR:	DY 7
* DATE OF SUBMISSION:	9/29/2012

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	$ 428,750.00
Increase Training of Primary Care Workforce	
Implement and Utilize Disease Management Registry Functionality	$ 2,572,500.00
Enhance Interpretation Services and Culturally Competent Care	$ 857,500.00
Collect Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities	
Enhance Urgent Medical Advice	$ 857,500.00
Introduce Telemedicine	
Enhance Coding and Documentation for Quality Data	
Develop Risk Stratification Capabilities/Functionalities	
Expand Specialty Care Capacity	$ 1,143,333.33
Enhance Performance Improvement and Reporting Capacity	
TOTAL CATEGORY 1 INCENTIVE PAYMENT:	$ 5,859,583.33
Category 2 Projects	
Expand Medical Homes	$ 806,240.65
Expand Chronic Care Management Models	
Redesign Primary Care	$ 268,746.38
Redesign to Improve Patient Experience	
Redesign for Cost Containment	
Integrate Physical and Behavioral Health Care	$ 1,612,481.30
Increase Specialty Care Access/Redesign Referral Process	
Establish/Expand a Patient Care Navigation Program	$ 1,209,360.97
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:	$ 3,896,829.30
Category 3 Domains	
Patient/Care Giver Experience *(required)*	$ 1,206,562.50
Care Coordination *(required)*	$ 1,206,562.50
Preventive Health *(required)*	$ 1,206,562.50
At-Risk Populations *(required)*	$ 1,206,562.50
TOTAL CATEGORY 3 INCENTIVE PAYMENT:	$ 4,826,250.00
Category 4 Interventions	
Severe Sepsis Detection and Management *(required)*	$ 252,083.33
Central Line Associated Blood Stream Infection Prevention *(required)*	$ 252,083.33
Surgical Site Infection Prevention	
Hospital-Acquired Pressure Ulcer Prevention	$ 378,125.00
Stroke Management	
Venous Thromboembolism (VTE) Prevention and Treatment	$ 255,864.58
Falls with Injury Prevention	
TOTAL CATEGORY 4 INCENTIVE PAYMENT:	$ 1,138,156.24
TOTAL INCENTIVE PAYMENT	$ 15,720,818.87

DSRIP Semi-Annual Reporting Form

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

DPH SYSTEM:	Kern Medical Center
REPORTING YEAR:	DY 7
DATE OF SUBMISSION:	9/29/2012

Category 1 Summary Page

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

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

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

Category 1 Projects		
Expand Primary Care Capacity		
Process Milestone:	Implement a nurse triage software system to assist nurses in determining the acuity of patients	Yes
Achievement Value		*1.00*
Process Milestone:	Hire and train at least 2 additional primary care nurses	Yes
Achievement Value		*1.00*
Improvement Milestone:	Provide 20% of patients that request urgent appointments, an appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within 3 calendar days of request.	0.42
Achievement Value		*1.00*
DY Total Computable Incentive Amount:		$ 2,572,500.00
Total Sum of Achievement Values:		3.00
Total Number of Milestones:		3.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 2,572,500.00
Incentive Funding Already Received in DY:		$ 2,143,750.00
Incentive Payment Amount:		$ 428,750.00

Category 1 Summary Page

Implement and Utilize Disease Management Registry Functionality

Improvement Milestone:	Expand registry report services to provide on-demand, operational, and historical capabilities, inclusive of reports to care providers, managers, and executives.	Yes
Achievement Value		*1.00*
Improvement Milestone:	Conduct staff training for at least 10 staff on populating and using the registry.	Yes
Achievement Value		*1.00*
DY Total Computable Incentive Amount:		$ 2,572,500.00
Total Sum of Achievement Values:		2.00
Total Number of Milestones:		2.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 2,572,500.00
Incentive Funding Already Received in DY:		$ -
Incentive Payment Amount:		$ 2,572,500.00

Enhance Interpretation Services and Culturally Competent Care

Process Milestone:	Train 50% of direct patient care staff and/or providers in inpatient area to appropriately utilize health care interpreters (via video, phone, or in person).	0.92
Achievement Value		*1.00*
Process Milestone:	Develop and implement a training program for 10 inpatient “champions” to improve cultural competency.	1.20
Achievement Value		*1.00*
Process Milestone:	Develop a plan to expand the interpreter technology to additional patient care areas within the hospital and its outpatient clinics	Yes
Achievement Value		*1.00*
Improvement Milestone:	Improve language access through a 5% increase from baseline in qualified interpreter encounters per month.	1.41
Achievement Value		*1.00*
DY Total Computable Incentive Amount:		$ 3,430,000.00
Total Sum of Achievement Values:		4.00
Total Number of Milestones:		4.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 3,430,000.00
Incentive Funding Already Received in DY:		$ 2,572,500.00
Incentive Payment Amount:		$ 857,500.00

Category 1 Summary Page

Enhance Urgent Medical Advice

Process Milestone:	Inform and educate an additional 5,000 (10,000 total) patients on the nurse advice line.	Yes
Achievement Value		*1.00*
Process Milestone:	Develop and distribute 5,000 patient-focused educational newsletters with proactive health information and reminders.	Yes
Achievement Value		*1.00*
Improvement Milestone:	Increase in the number of patients that accessed the nurse advice line by 10% over baseline established in Year 1.	1.70
Achievement Value		*1.00*
DY Total Computable Incentive Amount:		$ 5,145,000.00
Total Sum of Achievement Values:		3.00
Total Number of Milestones:		3.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 5,145,000.00
Incentive Funding Already Received in DY:		$ 4,287,500.00
Incentive Payment Amount:		$ 857,500.00

Expand Specialty Care Capacity

Process Milestone:	Conduct a specialty care gap analysis based on community need by assessing specialty clinic supply and demand, capacity and productivity.	Yes
Achievement Value		*1.00*
Process Milestone:	Establish 3 specialty care guidelines for the high impact/most impacted medical specialties identified in the gap analysis.	Yes
Achievement Value		*1.00*
Improvement Milestone:	Based on results of gap analysis, increase the number of specialist providers and/or clinic hours available for at least 2 high impact/most impacted medical specialties identified in the gap analysis.	Yes
Achievement Value		*1.00*
DY Total Computable Incentive Amount:		$ 3,430,000.00
Total Sum of Achievement Values:		3.00
Total Number of Milestones:		3.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 3,430,000.00
Incentive Funding Already Received in DY:		$ 2,286,666.67
Incentive Payment Amount:		$ 1,143,333.33

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DPH SYSTEM: Kern Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/29/2012

Category 2 Summary Page

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

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

- The black boxes indicate Milestone achievements, either "yes/no", or the actual achievement # or %.
- 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:	Put in place policies and systems to enhance patient access to the medical home	Yes
Achievement Value		*1.00*
Improvement Milestone:	Assign at least 1500 of eligible patients (where eligible is defined as eligible for Kern County's LIHP program) to medical homes.	1.79
Achievement Value		*1.00*
Improvement Milestone:	At least 40% of new patients assigned to medical homes will be contacted for their first patient visit within 120 days.	0.72
Achievement Value		*1.00*
DY Total Computable Incentive Amount:		$ 3,224,962.60
Total Sum of Achievement Values:		3.00
Total Number of Milestones:		3.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 3,224,962.60
Incentive Funding Already Received in DY:		$ 2,418,721.95
Incentive Payment Amount:		$ 806,240.65

Category 2 Summary Page

Redesign Primary Care

Process Milestone:	Implement patient visit redesign in primary care clinics	Yes
Achievement Value		*1.00*
Process Milestone:	Implement the patient-centered scheduling model in primary care clinics	Yes
Achievement Value		*1.00*
Process Milestone:	Implement practice management system	Yes
Achievement Value		*1.00*
DY Total Computable Incentive Amount:		$ 3,224,962.10
Total Sum of Achievement Values:		3.00
Total Number of Milestones:		3.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 3,224,962.10
Incentive Funding Already Received in DY:		$ 2,956,215.72
Incentive Payment Amount:		$ 268,746.38

Integrate Physical and Behavioral Health Care

Process Milestone:	Train at least 20 additional (35 total) primary care clinicians on primary care management of behavioral health conditions	Yes
Achievement Value		*1.00*
Process Milestone:	Co-locate behavioral health and primary care, as measured by at least 2 behavioral health providers in primary care clinics.	Yes
Achievement Value		*1.00*
Process Milestone:	Development of a tracking mechanism of referrals from primary care providers to on site behavioral health professionals.	Yes
Achievement Value		*1.00*
DY Total Computable Incentive Amount:		$ 4,837,443.90
Total Sum of Achievement Values:		3.00
Total Number of Milestones:		3.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 4,837,443.90
Incentive Funding Already Received in DY:		$ 3,224,962.60
Incentive Payment Amount:		$ 1,612,481.30

Category 2 Summary Page

Establish/Expand a Patient Care Navigation Program

Process Milestone:	Increase patient engagement, by completing 5 patient engagement initiatives.	Yes
Achievement Value		*1.00*
Process Milestone:	Expand program to include ED Navigator, who educates patients on importance of primary care; connects patients to a new Primary Care Clinic and/or assists patient in getting following appointment with established PCP.	Yes
Achievement Value		*1.00*
DY Total Computable Incentive Amount:		$ 4,837,443.90
Total Sum of Achievement Values:		2.00
Total Number of Milestones:		2.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 4,837,443.90
Incentive Funding Already Received in DY:		$ 3,628,082.93
Incentive Payment Amount:		$ 1,209,360.97

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DPH SYSTEM: Kern Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/29/2012

Category 3 Summary Page

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

* *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
DY Total Computable Incentive Amount:	$ 2,413,125.00
Total Sum of Achievement Values:	1.00
Total Number of Milestones:	1.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 2,413,125.00
Incentive Funding Already Received in DY:	$ 1,206,562.50
Incentive Payment Amount:	$ 1,206,562.50
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
DY Total Computable Incentive Amount:	$ 2,413,125.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	2.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 2,413,125.00
Incentive Funding Already Received in DY:	$ 1,206,562.50
Incentive Payment Amount:	$ 1,206,562.50

Category 3 Summary Page

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*
DY Total Computable Incentive Amount:	$ 2,413,125.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	2.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 2,413,125.00
Incentive Funding Already Received in DY:	$ 1,206,562.50
Incentive Payment Amount:	$ 1,206,562.50

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*
DY Total Computable Incentive Amount:	$ 2,413,125.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	2.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 2,413,125.00
Incentive Funding Already Received in DY:	$ 1,206,562.50
Incentive Payment Amount:	$ 1,206,562.50

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

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 (%)		0.60
Achievement Value		*1.00*
Optional Milestone:	Implement the Sepsis Resuscitation Bundle	Yes
Achievement Value		*1.00*
DY Total Computable Incentive Amount:		$ 1,512,500.00
Total Sum of Achievement Values:		2.00
Total Number of Milestones:		2.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 1,512,500.00
Incentive Funding Already Received in DY:		$ 1,260,416.67
Incentive Payment Amount:		$ 252,083.33

Category 4 Summary Page

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

Compliance with Central Line Insertion Practices (CLIP) (%)		0.92
Achievement Value		1.00
Optional Milestone:	Implement the Central Line Insertion Practices (CLIP)	Yes
Achievement Value		*1.00*
Optional Milestone:	Report at least 6 months of data collection on CLIP to SNI for purposes of establishing the baseline and setting benchmarks.	Yes
Achievement Value		*1.00*
DY Total Computable Incentive Amount:		$ 1,512,500.00
Total Sum of Achievement Values:		3.00
Total Number of Milestones:		3.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 1,512,500.00
Incentive Funding Already Received in DY:		$ 1,260,416.67
Incentive Payment Amount:		$ 252,083.33

Category 4 Summary Page

Hospital-Acquired Pressure Ulcer Prevention

Prevalence of Stage II, III, IV or unstagable pressure ulcers (%)		0.03
Achievement Value		1.00
Optional Milestone:	Share data, promising practice, and finding with SNI to foster shared learning and benchmarking across the California public hospitals	Yes
Achievement Value		*1.00*
DY Total Computable Incentive Amount:		$ 1,512,500.00
Total Sum of Achievement Values:		2.00
Total Number of Milestones:		2.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 1,512,500.00
Incentive Funding Already Received in DY:		$ 1,134,375.00
Incentive Payment Amount:		$ 378,125.00

Category 4 Summary Page

Venous Thromboembolism (VTE) Prevention and Treatment

Optional Milestone:	Implement the VTE prevention program	Yes
Achievement Value		*1.00*
Optional Milestone:	Report at least 6 months of data collection on VTE process measures to SNI for purposes of establishing the baseline and setting benchmarks.	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		
DY Total Computable Incentive Amount:		$ 1,535,187.50
Total Sum of Achievement Values:		2.00
Total Number of Milestones:		2.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 1,535,187.50
Incentive Funding Already Received in DY:		$ 1,279,322.92
Incentive Payment Amount:		$ 255,864.58

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

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: * $ 2,572,500.00

Incentive Funding Already Received in DY: * $ 2,143,750.00

Process Milestone: Implement a nurse triage software system to assist nurses in determining the acuity of patients
(insert milestone)

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

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

Achievement: Yes

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

In July 2011, we evaluated three different software vendors for the nurse triage system. KMC used the following functionality specifications for Nurse Triage Software:
1. Must have evidence-based protocols by Barton Schmidt and David Thompson
2. Must include both pediatric and adult protocols
3. Must document every step taken to reach the triage conclusion
4. Must save records, for audit and documentation processes
5. Entire triage documentation must be able to be copied and pasted into an electronic medical record
6. Must include reporting, at a minimum of:
   a. Disposition of each patient triaged
   b. Total number of patients triaged in a given date range
   c. Number of patients needing an appointment who received an appointment
7. Must include training for users

All three systems include the following basic functionality:
1. All three use the same evidence-based protocols by Barton Schmidt and Thompson
2. All include both pediatric and adult protocols
3. All document every step taken to get to the triage conclusion which can be copied into the EMR

However, TriageLogic has no reporting capability, nor stores the data in the software. This would make it nearly impossible for KMC to report on the number of patients needing urgent appointments. LVM Systems and Fonemed both have reporting functionality, but Fonemed is far more expensive than LVM Systems (see pricing comparison below). Adding to the cost is that Fonemed charges per call and KMC experiences an extremely high volume of calls. LVM Systems also has a queuing functionality, so that our schedulers can answer the call and list patients into a queue. KMC selected LVM Systems.

The vendor contract was signed on November 15, 2011. After the contract was signed we had a 3-day training session on the system in which we determined the specifications for reporting and we documented a flow process for how triage calls would be handled. On March 4th, the calls for pediatrics were first triaged. By the third week of March, the triage process had expanded to all primary care clinics. The implementation of this process helped with two issues. Because urgent appointments were always given on a first-come-first served basis, the majority of patient calls would come in at 7:30AM (when the phone lines opened). This created a flood of calls early in the morning, many of which could not be answered. With the new process, the schedulers put the patients on a call-back queue, and nurses will call them back, while going through the triage protocols. Second, the implementation of the system has allowed us to provide urgent appointments to those who need it most, so that patients who require an appointment are not told that they need to be seen in the emergency department.

Achievement of this milestone was based on the metric of signing the vendor contract.

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: Hire and train at least 2 additional primary care nurses
(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

Two additional primary care nurses were hired specifically to support the expansion of the primary care clinics and assist with triaging patients needing urgent appointments. One nurse was hired in August 2011, while another was hired in October 2011. Since being hired, they have been trained on the electronic medical record, the workflows and nursing needs of pediatrics, medicine, family medicine, and OB/GYN clinics, and scheduling of appointments. With the implementation of the nurse triage system, they transitioned full-time to triaging patients requesting same-day appointments. In addition, the two triage nurses, along with the supervisors of the primary care clinics were trained over a course of three days in April (April 2, 6, and 25) on the new nurse triage system. Training materials were provided by the vendor (LVM Systems). Our future plan is to cross-train at least one additional nurse in each primary care clinic on the nurse triage software, so that the phones are always covered, and so that nurses can rotate duties to avoid fatigue. We believe that this rotation will enable the system to be maintained and to expand quickly in the event that our call volume warrants additional nurses.

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

Category 1: Expand Primary Care Capacity

Improvement Milestone: Provide 20% of patients that request urgent appointments, an appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within 3 calendar days of request.

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	7,192.00
Denominator (if absolute number, enter "1")	*	17,160.00
Achievement		0.42

If "yes/no" as to whether the milestone has been achieved, 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

KMC operates four primary care clinics: pediatrics, family practice and two internal medicine clinics. At the beginning of DY7, the clinics had limited capacity to see patients needing urgent appointments, and the wait time for the next available date for non-urgent appointments was 60 days. Although at the beginning of DY7, three clinics had same-day appointment slots, the supply was still limited. Therefore, patients would call the appointment line as early as possible to receive these appointments, creating a backlog in the number of calls that can be answered, and long wait times for a scheduler via phone.

In order to increase the number of urgent appointments available to patients, KMC did the following: 1) revamped clinic schedules to allow for a set amount of same-day appointments in all clinics; 2) dedicated at least one provider to same-day appointments each day of the week, so there was always someone that could see urgent appointments; and 3) implemented the nurse triage software to schedule appointments based on acuity.

The numerator for this measure is the number of patients provided an urgent appointment within 3 days, and the denominator is the number of patients triaged as needing a primary care appointment within three days. Prior to this initiative only 10-15% of patients were getting same day appointments within 3 days.

Below are the percent of patients that received same day appointments within 3 days over the course of this demonstration year.
July – 26%
August – 33%
September – 28%
October – 21%
November – 28%
December – 37%
January – 42%
February- 55%
March – 72%
April – 81%
May – 71%
June – 83%

Because we began collecting this measure prior to the nurse triage software and protocols being in place, in the denominator, we had to include all patients who requested a same day appointment. We also only provided same day appointments, because our clerks were not nurses who could determine which patients could be seen in one day versus three days. For each day, scheduling clerks would fill out the number of patients who called asking for a same-day appointment for a primary care clinic, and the number of patients who were able to be scheduled. Each clinic supervisor tabulated the numerator and denominator in monthly stats logs. The results were compiled at the end of each month in a monthly dashboard. For each individual month, the results were always above 20%. In September, we had a provider leave that saw primarily same day patients. During these months, methods to resolve the issue were discussed weekly, and included changing one 3rd year resident's schedule to see same-day appointments only on specific days. Later, the addition of another internal medicine provider, and another Physician's Assistant helped keep the number above goal value.

Once the nurse triage system went live, we were able to automate the reporting of this measure, so that the denominator included those patients who requested urgent appointments and were triaged with the following dispositions:
1) See today in office
2) See now in office
3) See now in ED or office
4) See today or tomorrow in office
5) See PCP when office is open (within 72 hours)
6) See Physician within 24 hours

And the numerator included only those patients who had one of these dispositions, and the date of appointment was less than 3 days from the date of the call. The results of these reports are presented to the Board of Supervisors and indicate that a majority of our patients who need an appointment are able to get an appointment. Currently, the clinics are only open during the weekdays and have no evening or weekend hours. Our next step is the expansion of our primary care clinics (as outlined as our year 3 milestone) to enable even a greater number of patients to be seen in a timely manner.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	*	0.20
Achievement Value		1.00

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

REPORTING ON THIS PROJECT: * Yes

Category 1: Implement and Utilize Disease Management Registry Functionality

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

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

Implement and Utilize Disease Management Registry Functionality

DY Total Computable Incentive Amount: * $ 2,572,500.00

Incentive Funding Already Received in DY: * $ -

Improvement Milestone: Expand registry report services to provide on-demand, operational, and historical capabilities, inclusive of reports to care providers, managers, and executives.

(insert milestone)

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

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

Achievement: Yes

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

In November 2011, the Board of Supervisors approved the purchase of a more robust registry than was previously in place at KMC which will enable KMC to have much expanded reporting capability. Initially KMC was planning on expanding the use of a registry that it already had; however, while planning for the expansion we decided that it would be more beneficial to purchase a new registry that will automatically pull data from our practice management and EMR systems, as opposed to being manually entered. KMC purchased i2i Tracks, which allows KMC to report on individual patients, provide recall letters to patients, and provide summary data to physicians, managers and executives. Once the implementation of the system started, the implementation team put together a list of all of the reports it would want to generate out of the system. The list of reports is a compilation of Hedis measures, meaningful use measures, and category 3 care coordination and population health measures. A protocol was then drafted which includes the following:
1. The definition of the measure
2. The system where each data point must be documented in order to report appropriately
3. The primary system for pulling the report
4. When the report will be pulled
5. The intervention or proposed method for improving the measure (ie. reports to physicians, recall letters to patients)
6. The audience for reporting the measure
This now serves as the foundation for the creation of a complete outpatient quality policy.

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: Conduct staff training for at least 10 staff on populating and using 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

CDEMS was KMC's old disease registry. CDEMS is a free application that was developed by the Washington State Diabetes Program in 2002. It was introduced to KMC by the Safety Net Institute (SNI) in 2008. Multiple other safety net hospitals have also used or are using CDEMS. However, in 2010, it was to longer being utilized by our staff for the following reasons:

- Is not a software, it is an access database
- It requires a dedicated staff person to enter all of the information into the record. Even with the EMR, it would require the data to be exported on a regular basis into an Excel database (which would require IS time to run the reports to export the data), and then imported into CDEMS.
- Limited in its ability to interface with other data systems
- Lacking proper reporting functionality

In KMC's search for a new disease registry, we asked SNI for a list of registries that their members (other public hospitals) use. Nearly all of the hospitals that do not have homegrown systems or systems with their EMR have i2i Tracks or are moving towards i2i Tracks from their current system. This includes Alameda County, all of LA County, SF General (both clinics and the hospital) and San Joaquin General hospital. Additionally, both large Federally Qualified Health Centers (FQHCs) in Kern County already use i2iTracks.

Some of the functionality we were looking for:

- Population management tools and reports
- Ability to configure patient alerts
- At-a-glance patient print-outs
- Allows for interfaces with practice management system, EMR and local lab agency
- Easily change reports—analytics report writers. Just point and click, no code necessary
- Creates letters that can be sent to patients reminding them of exams needed
- Tracks referrals and the status of referrals

So in November 2011, the Board of Supervisors approved the purchase of i2iTracks for KMC. Staff training on populating and using the registry was conducted in June. The training participants consisted of each clinic supervisor, representatives from the IT department, disease registry project manager, and a medical support technician from each of the clinic areas. By including front line staff, IT, project managers, and supervisors, the training enabled input from each area whose workflow would be affected by the new system. The training was provided by an i2i Systems trainer. Training included: 1) patient demographics; 2) visit and appointment history; 3) interface options; 4) labs; 5) referrals; 6) tracking types; 7) reports; 8) letters; 9) workflow analysis; 10) disease management set-up

* Yes

Achievement Value: 1.00

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Kern Medical Center
REPORTING YEAR: DY7
DATE OF SUBMISSION: 9/30/2012

REPORTING ON THIS PROJECT: * Yes

Category 1: Enhance Interpretation Services and Culturally Competent Care

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

DY Total Computable Incentive Amount:	* $ 3,430,000.00
Incentive Funding Already Received in DY:	* $ 2,572,500.00

Process Milestone: Train 50% of direct patient care staff and/or providers in inpatient area to appropriately utilize health care interpreters (via video, phone, or in person).
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	* 628.00
Denominator (if absolute number, enter "1")	* 679.00
Achievement	0.92

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

HCIN team developed and completed "How to use Interpretative Services" education for both licensed RN/LN staff and Medical Staff faculty. Education outline: 1) Laws that apply to Interpertative Services; 2) Plan to Enhance Interpreter services and cultural competent care; 3) How this Service will Help; 4) Significant Healthcare Services that Require Clinical Healthcare Interpretation; 5) Documentaion of Interpretative servcie; 6) How to Get Interpretative Service- Who to Call; 7) Review of How to Use Equipment; 8) Improving Services - What HCIN Interpreters need to Interpret . As of June 2012 628/679 =92% have completed education. Goal was 85%. Education is ongoing. Education effectiveness is monitored through increase in use of interpretative services from baseline established in DY6.

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

Category 1: Enhance Interpretation Services and Culturally Competent Care

Process Milestone: Develop and implement a training program for 10 inpatient “champions” to improve cultural competency.

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * 12.00

Denominator (if absolute number, enter "1") * 10.00

Achievement 1.20

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

The Interpretative Service team selected the U.S. DHHS - Minority Health Service program “Culturally Competent Nursing Care: A Cornerstone of Caring” for initial training of the 10 Cultural "Champions". The team recruited 12 staff to participate in the " cultural competency champions" program. The “learning objects are: 1) Define concepts related to culturally and linguistically appropriate services in nursing practice; 2) Identify strategies to promote self-awareness about attitudes, beliefs, biases, and behaviors that may influence the nursing care or services they provide.; 3) Devise strategies to enhance skills toward the provision of culturally and linguistically appropriate services.; and 4) Demonstrate the advantages of the adoption of the National Standards for Culturally and Linguistically Appropriate Services in their practice. The program consists of three (3) courses which have modules that are completed online. Each “cultural champion” completes: 1) a pre-test; 2) module; and 3) a post test for each course. Outline of Course with individual modules are as follows: Course 1: Module 1.1 “Principles of Cultural Competence”; Module 1.2 “The Importance of Self-Awareness; Module 1.3 “Models for becoming Culturally Aware; 1.4 “Understanding the Health-Related Experience; Module 1.5”Delivering Patient Centered Care”; Module 1.6 “Balancing Knowledge-Centered and Skill-Centered Approaches” . Course 2: Module 2.1 “Overview of Effective Communication Between Patient and Nurse”; Module 2.2 “Tools for Effective Communication”; Module 2.3 “Overview of Language Access Services”; Module 2.4 “When Interpreter Services are Needed”; Module 2.5 “Role of Health Literacy in Effective Communication”; Module 2.6 “When Written or Translated Materials are Needed”. Course 3: Module 3.1 “Culturally Competent Organizations”; Module 3.2 “Nurses’ Roles as Advocates for Cultural Competence in Organizations”; Module 3.3 “Organizational Assessment”; Module 3.4 “Strategic Planning”; Module 3.5 “Training and Education”; Module 3.6 “Developing Partnerships”. A certification is provided at the completion of the course. The employee upon completion provides a copy of their certificate to the team for tracking in the organization’s education database. During DY7 a total of 12 “champions” for the impatient area completed the certification program. We exceeded our goal. A policy was developed to describe the champion program. The “champions” will assist the organization in development and implementation of cultural competence education programs and project for KMC throughout DY8, 9 and 10. Tracking of "champions" has been developed to ensure that new champions are trained as needed to allowfor a consistant number of 10 or more for organizational ongoing education.

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

Achievement Value 1.00

Process Milestone: Develop a plan to expand the interpreter technology to additional patient care areas within the hospital and its outpatient 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

The Interpretive services team completed an inventory in DY6. After analysis, 26 video units, 29 polycom phones and 22 Panasonic phones will need to be purchased to increase technology to patient care areas within the hospital and outpatient clinics. This will allow KMC to reach an increase of more than 5% from baseline in DY8 and then 10% from baseline in DY9. In addition the IS department has completed the wireless requirements and has updated all available video units' software. Staff can immediately put the unit into use. This has increased interpretive services equipment access by 50% without any purchase of equipment.

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

Achievement Value 1.00

Category 1: Enhance Interpretation Services and Culturally Competent Care

Improvement Milestone: Improve language access through a 5% increase from baseline in qualified interpreter encounters per month.

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	2,160.00
Denominator (if absolute number, enter "1")	*	1,533.75
Achievement		1.41

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

We account for the increase in usage in DY7 from baseline in DY6 to the following: 1) HCIN team development and completion of "How to use Interpretative Services" education for both licensed RN/LN staff and Medical Staff faculty. As of DY7 July 2011 - June 2012 628/679 =92% have completed education. Education is ongoing. 2) In addition, the organization went wireless with implementation of new EMR which allowed the use of the wireless feature of video units for interpreter service. This has increased staff access to interpretative services by 50%.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	*	0.05
Achievement Value		1.00

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

REPORTING ON THIS PROJECT: * Yes

Category 1: Enhance Urgent Medical Advice

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

DY Total Computable Incentive Amount: * $ 5,145,000.00

Incentive Funding Already Received in DY: * $ 4,287,500.00

Process Milestone: Inform and educate an additional 5,000 (10,000 total) patients on the nurse advice line.
(insert milestone)

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

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

Achievement: Yes

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

In August 2011, Kern Medical Center mailed a memo regarding the 24/7 Nurse Line and Health Information Library to 6868 patients. In order to inform new patients, KMC also added this information to the Welcome Letter of the Low Income Health Program (LIHP) program members enrolled in Kern County. On average this information is mailed to 300-500 patients each month.

The 24-hour Nurse Helpline Program utilizes registered nurse counselors who assess callers' symptoms to assist them in determining the appropriate health care action to take. With the use of an extensive clinical database of health information and care guidelines, callers receive advice, education and counseling to meet a wide variety of health care concerns. Callers also have access to a Health information Library with prerecorded information on over 1,000 health related topics. Five hundred-fifty topics are now available in Spanish; however, Nurse Line help is available in multiple languages.

In order to understand who is calling the 24/7 Nurse Line, KMC receives monthly, quarterly and annual reports. The types of information reported on these reports are:

- Total number of symptom based calls
- Total number non-urgent health information calls
- Total number of non-health information calls
- Disposition of each call, broken down into the following categories
  - Were advised to call 911 now
  - Were advised to go to the emergency room
  - Were advised to see their physician within now, 4 hrs, 24 hrs, 72 hrs, 2 weeks
  - Was advised to call poison control
  - Were assisted by the receiving home care advice
- Top ten triage guidelines used
- Number of callers with original intent to go to ED that were given health counseling/information and/or directed to see an MD within X number of days
- Call summaries by day of week and caller demographics

To further inform and educate patients about the 24/7 Nurse Line and Health Information Library, we made flyers and distributed these to our providers. This way, office staff could assist in the education of patients regarding the 24/7 Nurse Line and Health Information Library. The information provided in the monthly nurse line reports, help determine what topics we include in our Quarterly Patient Education Newsletter.

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

Achievement Value 1.00

Category 1: Enhance Urgent Medical Advice

Process Milestone: Develop and distribute 5,000 patient-focused educational newsletters with proactive health information and reminders.

(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

Full Milestone Description: Develop and distribute 5,000 patient-focused educational newsletters with proactive health information and reminders based on nurse advice line data/generated report identifying common areas addressed by the nurse advice line and topics searched for in the Health Information Library.
KMC mailed Fall, Winter, Spring and Summer patient focused educational newsletters to over 6,000 patients each quarter. All articles in the newsletters are written at a 5th grade reading level and all newsletters are mailed in both English and Spanish. KMC also makes sure the newsletters are culturally competent based on our patient population.
KMC uses a vendor, recommended by our Local Medi-Cal Initiative that provides a large, diverse article library to choose health topics from, translation services, and focuses on health literacy and education, as well as, visual/graphic suitability for our newsletters. In addition, the vendor provides KMC with a list of all patient mailing address updates from the US Postal Service so we can keep our patients demographic information as current as possible.
KMC plans to evaluate the effectiveness and helpfulness of the newsletters in an upcoming member satisfaction survey scheduled for the winter of 2012.
In August 2011, the newsletter focused on the following information:
- Flu Shots: When and where to get flu shots; the benefits of getting a flu shot and when someone should not get the vaccine
- Check-up on your health: Focused on preventative tests like cholesterol, blood pressure, diabetes, colorectal cancer, breast cancer, cervical cancer and osteoporosis
- Public Health Clinics: Emphasized that public health helps maintain the safety and health of the local community by providing health education, immunizations, family planning services, HIV counseling/screening, etc.

In November 2011, the newsletter focused on the following information:
- Preventing Pre-diabetes: Identified patient risk for pre-diabetes; tips to help treat and prevent diabetes
- Diabetic Eye Screenings: Listed potential eye problems with diabetes and how to protect your eyes
- 4 Steps to Holiday Health: 1) Eat well, 2) Move more, 3) Get your rest, and 4) Keep your spirits up
- Stress: Signs of too much stress and how to help alleviate stress

In February 2012, the newsletter focused on the following information:
- Emergencies: Where to go in an emergency and what is an emergency
- Maintaining Weight Loss: Detailing what causes a weight-loss plateau and how to get back on track to maintain weight loss
- Is it a cold or Allergies? Symptoms breakdown between colds and allergies, the article also detailed how to stay well (hand washing), how to treat a cold and what most allergies are caused by
- How to avoid asthma on the job: Symptoms of asthma and what irritates asthma

In May 2012, the newsletter focused on the following information:
- Safer Sunscreen: Changes to sunscreen labels, how to read them and what they mean
- Preventing insect bites and stings: What clothing to wear, insect repellent do's and do not's and other tips for preventing bites
- Osteoporosis: Who does Osteoporosis affect, risk factors, bone builder tips
- Calcium: Benefits of getting calcium in your diet, how much calcium you need every day, list of calcium rich foods

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

Category 1: Enhance Urgent Medical Advice

Improvement Milestone: Increase in the number of patients that accessed the nurse advice line by 10% over baseline established in Year 1.

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	
Denominator (if absolute number, enter "1")	*	
Achievement		1.70
If "yes/no" as to whether the milestone has been achieved, 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

For this milestone, KMC must increase access over baseline by 10% over the entire DSRIP year. Current increase is 170%. In the early months of DSRIP, KMC noticed a large fluctuation in the month-to-month increase – some months had a 0 percent increase and some months had a large increase. Once the 24/7 Nurse Line memo was mailed to all members, KMC saw a direct increase to the number of calls we received. Additionally, now that the memo is sent to all new LIHP members, we have seen the increase stabilize and grow with each month.

Also in February 2012, it was reported to KMC that on multiple occasions, only on the weekend, the member service line wasn't transferring to the 24/7 Nurse Line and patients were just getting a recording. We contacted our IS department and the Nurse Line vendor to troubleshoot. After a thorough review, we discovered a glitch with the after-hours phone tree routing. Consequently, we worked with IS and the Nurse Line to change the phone tree so it would always have an option to route to the 24/7 nurse line, especially after-hours. After identifying and fixing this issue, our number of monthly calls doubled the following month and has sustained.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	*	0.10
Achievement Value		1.00

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

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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Expand Specialty Care Capacity

DY Total Computable Incentive Amount: * $ 3,430,000.00

Incentive Funding Already Received in DY: * $ 2,286,666.67

Process Milestone: Conduct a specialty care gap analysis based on community need by assessing specialty clinic supply and demand, capacity and productivity.
(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

For the first half of the demonstration year, KMC drafted the scope of work for the gap analysis and vetted with appropriate stakeholders. Originally, we tried to go through a consultant for the analysis but there were multiple delays and issues so we will conduct the gap analysis in-house. The gap analysis looked at current KMC capacity; specialty clinic productivity and throughput; community needs assessment; and the federal, California and Kern County landscape come 2014. We also conducted a full SWOT Analysis. Below is a summary of some of the issues we identified, specialties in need of increased capacity, solutions outside just recruitment and lessons learned.
The largest environmental change impacting KMC is health reform and the expansion of coverage in 2014. In California alone, it is estimated that 7 million currently uninsured individuals will gain health coverage starting in 2014. Individuals will become insured through the expansion of Medicaid, new requirements for employers to offer coverage, and the creation of health benefit exchanges.
This change provides both an opportunity and a risk for KMC. KMC will have the opportunity to provide care to a larger proportion of paying patients. However, as uninsured patients become insured, they will no longer be required to receive services at KMC, the only safety net hospital in Kern County. In the next three years, KMC will need to transform from a provider of last resort to a provider of choice.
Identified Issues:
• A lack of specialty care providers accepting uninsured patients in the community, creates a reliance for specialty care on overburdened specialty clinics in safety net hospitals like KMC
• Lack of communication between specialists and primary care providers
• Inefficiencies in referral process
• Without a medical home, patients are followed up with specialists instead of being referred back to primary care provider
• Long wait time for specialty appointments
• Some patients travel long distances to receive care due to geographically large county with metro and rural areas
Specialties that need increased provider capacity: Neurology, Orthopedics, Endocrinology, Cardiology, Pain Management, Dermatology and Rheumatology.

One need discussed in the gap analysis, is the need for Telehealth at KMC. In an effort to improve access to certain

Category 1: Expand Specialty Care Capacity

specialties, KMC plans to use Telehealth to allow outside specialists the opportunity to provide support to providers at KMC and/or in rural areas of Kern County. KMC has been working with the National Multiple Sclerosis Society, Southern California and Nevada Chapter Executive Vice President, Susan Bradley, Regional Director, Kim Kotrla and UCLA Neurologist Dr. Barbara Giesser regarding a MS Telemedicine pilot with KMC. We are actively working to get Dr. Giesser credentialed and a contract in place. The MS Telemedicine clinic will run once a month in the Med Specialty clinic and the MS Society will pay for the telemedicine consults. This would be KMC's first Telehealth clinic.
Lessons Learned throughout the Gap Analysis process:
1) Understanding Patient Experience: Any changes made to processes must require staff to understand how patients are currently experiencing the system. For this reason, as part of our assessments, staff went through the process of attempting to schedule appointments through the scheduling phone system to identify what the patient experienced. A staff member also measured cycle time by following patients through the clinics to understand how long patients waited.
2) Importance of Good Data: When KMC first planned to conduct an assessment to determine the need to re-design the specialty care clinics, we found it very difficult to understand issues such as wait-times, the number of patients needing appointments, the number of referrals screened, etc. We realized that we needed the data to identify areas for improvement as well as to identify performance goals. We are working to standardize the methods by which data is collected, and staff has also been trained on how to correctly input information, so that meaningful data can be extracted.
3) Importance of Shadowing: Besides collecting quantitative data, an extremely valuable tool for understanding issues is to shadow and sit with staff in clinics. Several of KMC's staff including project managers and clinic directors shadowed the staff in clinics and were able to understand where bottlenecks occurred and where effort was being duplicated, which provided valuable information for the plans to redesign them.
4) Physician Buy-In: Any changes or plans to redesign care must have physician buy-in since they are responsible for providing care to the patient. KMC takes all physician recruitment requests and priorities to the KMC Board of Governors, a board comprised of the chair of each physician department at the hospital.
5) Trust: Relationships with stakeholders and trust are required for change to be successful. You cannot only bring data to the table; you must personalize problems with a specific patient example or story. We found it easier for the group to distance themselves from data.

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: Establish 3 specialty care guidelines for the high impact/most impacted medical specialties identified in the gap analysis.

(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

Besides primary care, KMC currently operates several specialty clinics, which include medicine specialties, orthopedics, eye, surgery and surgery specialties, and OB-GYN clinics. Since KMC is the only county, public hospital in Kern County, it is the primary source of specialty care for the safety net population. Wait times for high- demand specialties such as endocrinology and neurology clinic are 6.5 and 5.5 months respectively.
Due to issues with capacity and wait times for specialty care services at the medical center, it was imperative that KMC improve the referral process to the specialty care clinics. KMC developed a Referral Workgroup. The goal of the Referral Workgroup is to streamline the process for referring patients into specialty clinics from the community and KMC primary care clinics. The attendees include KMC administrators, primary and specialty care providers, referral clerks from the community clinics across Kern County, KMC clinic supervisors, KMC referral staff, and members from the KMC IS department.
Community clinic partnerships and participation has been an integral part of the success of the Referral Workgroup. Not only have the number of coalition members grown with our existing partners, we have invited new players and stakeholder to the table and opened up to conference calls allowing for more attendees each meeting. One expansion example is, the workgroup identified that a large number of inappropriate orthopedic and neurology referrals should really be directed to Physical Therapy; therefore, we have invited the KMC Physical Therapy Director to attend our workgroups each month.
Referral guidelines have been shown to reduce unnecessary referrals to specialty clinics, reduce wait times for patients who do need to see a specialist, and increase patient satisfaction. First, we developed a template for providers to use in creating their specialty care guidelines. Then we worked with the KMC Referral Workgroup to prioritize the specialty care guidelines from a KMC and community perspective.
Consensus specialty care guidelines were created through collaboration between primary care providers and specialists to delineate different levels of care and referral processes for each specialty area. Guidelines outline which diagnostic procedures need to be ordered and completed before a specialty consult, as well as indicate if and when a patient needs to be referred to a specialist. This demonstration year, the following guidelines have been created and finalized: Orthopedics, Rheumatology and Cardiology guidelines.

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

Achievement Value: 1.00

Improvement Milestone: Based on results of gap analysis, increase the number of specialist providers and/or clinic hours available for at least 2 high impact/most impacted medical specialties identified in the gap analysis.

(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

Due to long wait times for the KMC Cardiology and Endocrinology clinics, KMC has hired a Chief of Cardiology and Endocrinologist. Endocrinology had a 6.5 month wait time for new or routine patients, by hiring another Endocrinologist, all patients are now seen within 1-2 weeks of requesting a visit.

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

Achievement Value: 1.00

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

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 (*).*
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Expand Medical Homes

DY Total Computable Incentive Amount: * $ 3,224,962.60

Incentive Funding Already Received in DY: * $ 2,418,721.95

Process Milestone: 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

We wrote, received approval for and implemented several policies and systems to improve patient access to medical home.
1) We put in place systems for enhanced phone access by re-designing the patient appointment phone line. This allows calls for any clinic to go to the next available scheduler, instead of only being directed to one phone extension. In addition we purchased reporting software that enables supervisors to monitor the phone lines in real-time. Every month, reports are prepared and shared with the staff that shows the average time patients are on hold, the number of abandoned calls, and productivity per scheduler.

2) We implemented a primary care dashboard that is presented every month to the department chairs and executive team on key efficiency and access measures for ongoing quality improvement. Dashboard metrics include (data shown for all primary care clinics): 1) cycle time; 2) next third available appointment; 3) no-show rate; and 4) access to urgent appointments. The dashboard lists data for 4-12 months depending on the metric and each graph details current improvement initiatives taking place, as well as improvement goals that have been set by KMC. The Dashboard is updated every month and distributed to primary care providers, staff, Physician Board of Governors, and quarterly to the Quality Council.

3) The following access policies were also approved:
a. Pre-visit calls and responsibilities
b. Policy on providing aftercare instructions
c. Policy on providing appointments
d. Same day access and triage policy
e. Medication refills policy

Lastly, we realized that our diabetic population was in need of much greater coordination of care, which could be achieved by expanding the medical home for diabetic patients. In May, the director of KMC's clinics and administrators from Kern Health Systems, our local initiative met to create a single clinic where Kern Health Systems' diabetic patients can receive their diabetic foot screenings, eye exams, nutrition, education, and medication review and adjustments by a pharmacist, instead of receiving these services at five different clinic visits. KMC is currently working revising charge tickets for this clinic, credentialing clinical pharmacists, and contracting with a dietician. For more information regarding the new diabetic clinics, see Category 3 – Care Coordination, Diabetes Short Term Complications narrative.

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: Assign at least 1500 of eligible patients (where eligible is defined as eligible for Kern County's LIHP program) to medical homes.

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	2,687.00
Denominator (if absolute number, enter "1")	*	1,500.00
Achievement		1.79
If "yes/no" as to whether the milestone has been achieved, 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

KMC's goal is to establish a medical home for patients, where patients have a health care team that is tailored to the patient's health care needs, coordinates the patient's care, and proactively provides preventive, primary, routine and chronic care, so that patients may see their health improve, rely less on costly ED visits, incur fewer avoidable hospital stays, and report a greater patient experience of care. By the end of the demonstration year, KMC assigned 2687 eligible new patients (where eligible is defined as eligible for Kern County's LIHP program) to a medical home.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	*	1,500.00
Achievement Value		1.00

Improvement Milestone: At least 40% of new patients assigned to medical homes will be contacted for their first patient visit within 120 days.

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	718.00
Denominator (if absolute number, enter "1")	*	997.00
Achievement		0.72
If "yes/no" as to whether the milestone has been achieved, select "yes" or "no" from the dropdown menu, and provide an in-depth description of progress towards milestone achievement as stated in the instructions:	*	

The focus of this project is to increase the number of patients who come in for their first primary care visit (initial assessment) in a timely manner after being assigned to one of KMC's primary care clinics, and more specifically for 40% of new patients assigned to KMC to be contacted for their first patient visit within 120 days. Prior to this initiative, clinics were inconsistently contacting patients for their initial health assessments and some clinics were not contacting patients at all. All primary care clinics were not documenting whether or not they contacted the patient for their initial health assessment.
A policy and procedure was put in place for patients newly assigned to one of KMC's primary care clinics. The definition of "assigned" for this milestone were patients enrolled in the Kern Medical Center Health Plan (Kern County's Low Income Health Program and Medically Indigent Adult Program), who were assigned to a medical home in one of KMC's clinics as of July 2011. During the first week of each month, a report is generated of all patients who were assigned to one of KMC's primary care clinics the previous month, with their name, date of birth, phone number, address and clinic they were assigned to. Each clinic supervisor then assigns their staff to either call or send reminder letters for each patient assigned and document the date the contacts were made. A standard letter was drafted for all clinic to use when mailing reminders.
Prior to the policy being put in place, we noticed large inconsistencies, month to month and clinic to clinic. However, of the 997 patients newly assigned to one of KMC's primary care clinics from July 1, 2011 – June 30, 2012, KMC was able to contact 718 patients (72%). Unfortunately, the reminder process is still manual in nature and when letters are sent or calls are made within the 120 days, still varies between clinics and is based on clinic and staff availability. Moving forward, we would like to automate this process.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	*	0.40
Achievement Value		1.00

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

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 (*).*

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Redesign Primary Care

DY Total Computable Incentive Amount: * $ 3,224,962.10

Incentive Funding Already Received in DY: * $ 2,956,215.72

Process Milestone: Implement patient visit redesign in primary care clinics
(insert milestone)

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

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

Achievement: Yes

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

The metric is to implement the four components of redesign:
(1) Establish method to collect and report cycle time at least monthly: In July of 2011, we put together a policy that was distributed to all clinics to manually capture cycle times each month in all of the primary care clinics. Starting March 2012, we transitioned from manual capture of cycle times to automatic data capture. We developed a report with the implementation of our practice management system which records the times that patients were checked in for their appointment, and the time they were checked out.
(2) Compare cycle time to other potential measures of efficiency: To capture all measures of efficiency, we re-designed the monthly stats template that each clinic supervisor used to measure their efficiency in clinics. Prior to July 2011, the template reflected the number of patients scheduled, and the number seen. At the beginning of DY7, we added productivity and cycle time measurements as well. Monthly, a project manager summarizes all efficiency measures into a dashboard, which is reported to physician leaders and clinic staff. The dashboard presents: cycle time, productivity, no-show rates, dates of next available appointments, and the percent of patients who can receive appointments in an urgent manner. (3) Map patient visits from beginning to end to determine how time in the clinic is spent, and to identify any bottlenecks in the visit process: The project manager and clinic director shadowed ten patients through the clinics and mapped out bottlenecks in the flow. We realized that many of the bottlenecks arose from new flow changes resulting from the implementation of our EMR in May 2011 and our practice management system in March 2012. (4) Conduct a series of tests on the visit model, debrief thoroughly, and refine the model: Besides creating an overall flow for the clinics, we also made several large individual improvements to the documentation process in the EMR, which were previously creating large lags in patient care. This includes the following:
a) On 8/10/2011, we created a quick order menu in the EMR for ordering imaging exams from the clinic
b) On 10/19/2011, we created a quick order menu in the EMR for labs ordered from outpatient clinics
c) On 10/13/2011, we trained nursing attendants to enter in home medications and chief complaints in the patient room while waiting for the provider
d) On 3/1/2012, dictation microphones were rolled out in the clinics to allow for real-time text to speech dictation.
In addition to these improvements, in May we cross-trained schedulers on registration duties in order to improve the bottleneck in registration that resulted from transitioning to a new practice management system. The final flow was presented to all clinic managers on June 6, 2012.

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: Implement the patient-centered scheduling model in primary care clinics
(insert milestone)

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

The milestone included the completion of two phases of the redesign project: (1) Record, document, and examine random patient calls so that staff are able to experience the process of trying to make an appointment from the patient's perspective, (2) Call patients in advance to confirm their appointments, pre-register patients, update insurance and demographic information, – and if it makes sense, reschedule the appointment if there is a better time for the patient. For the first measure, we implemented a programming change to our phone system that allows supervisors in each clinic area to listen in on patient calls for patients who call in to the scheduling line trying to schedule an appointment. A qualitative data collection tool was used for the listener to rate the call and rate whether they felt the patients were receiving what they needed and were satisfied with the appointment they were given. For the second measure, we hired somebody solely dedicated to call patients in advance of their appointments and remind them of their appointments. She will also reschedule patients if necessary. Our registration staff also pre-register all of the patients. In addition, we have put together a process that patients being scheduled for same-day appointments are pre-registered when they are making their appointment, so that the pre-registration process does not need to happen when they walk in. We also continued to re-design scheduling by re-creating our scheduling process through the practice management system, which allows schedulers to book patients into any open time slot, as opposed to specific time slots reserved for only certain types of appointments (as was done previously). This has created a greater use of available appointment slots, and greater flexibility with scheduling. The practice management system also includes a "scheduling by request" option that allows schedulers to search for appointments that meet the specific needs of the individual. Lastly, in June we approved an agreement with ClientTell, a system that will provide automated reminder calls to patients prior to their appointments. By implementing this system, we can ensure that regular reminder calls to patients will be sustained.

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: Implement 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

Completion for this milestone was the documentation of a signed vendor contract. On October 10, 2011, the Board of Supervisors approved the implementation of the McKesson Practice Management System. After the contract was signed, KMC went through a four month implementation phase, which included designing and executing a bi-directional interface between the practice management system, the hospital registration system, and our EMR. In addition, approximately 100 staff members were trained on scheduling, registration, billing and IT maintenance with the new system. The practice management system is being used in every outpatient clinic as of March 1, 2012. This system has enabled every patient to be registered only one time, instead of the previous flow which required patients to be registered for every single visit. It also automatically verifies insurance eligibility for every patient two days prior to their appointment, to enable quicker pre-registrations. In addition, it has allowed our schedulers to schedule patients according to patient preference and has allowed for more scheduling flexibility. Lastly, it has enabled for more robust reporting on metrics such as percentage of appointment slots used, cycle times, an no-show rates.

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

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

REPORTING ON THIS PROJECT: * Yes

Category 2: Integrate Physical and Behavioral Health Care

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

DY Total Computable Incentive Amount: * $ 4,837,443.90

Incentive Funding Already Received in DY: * $ 3,224,962.60

Process Milestone: Train at least 20 additional (35 total) primary care clinicians on primary care management of behavioral health conditions
(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

With the implementation of the Low Income Health Program (LIHP), counties across California have the opportunity to fully integrate physical and behavioral health services and providers under one plan. In an effort to combine county services and care coordination among safety net physical and behavioral health providers, Kern Medical Center (KMC) created a Physical and Behavioral Health Integration Committee, composed of county/community experts, key stakeholders, and primary care, mental health and substance abuse providers that convene with the goal of creating an opportunity for collaboration, integration, coordination and continuity of care for patients transitioning between both systems. The committee has been tasked with determining how to continually improve the care and quality of services provided to LIHP members that struggle with both physical and behavioral health issues. KMC also hired a Behavioral Health Coordinator, who started on November 1, 2011. We discuss more details of the Physical and Behavioral Health Integration Committee in the Patient Engagement initiatives under the Patient Care Navigation report.

In order to expand education opportunities, KMC hosted an integration workshop. The workshop addressed evidence-based, patient centered models and the importance of cross system linkage between providers, as well as the benefits of integrated care with an interdisciplinary team. There were 89 attendees at this workshop. Workshop activities included:

- Lecture presentation: “Introduction to Integration with an Interdisciplinary Team”
- Video examples of warm hand-offs in the primary care setting
- Problem Based Learning Case Study: Double Trouble

The case study was broken into three phases. Each phase participants were given information/facts needed in order to generate a hypotheses and action plans. As a team, the participants needed to look at the data and work towards a diagnosis. By the end of Phase III, the participants should have collectively reached a diagnosis. The Case Study was about a 34 year old woman who presents with personality traits resembling histrionic personality disorder. She develops diplopia, and we begin to wonder about a diagnosis of a somatoform disorder. As the case progresses it becomes clear that this is not the only possible diagnosis, and there is an ultimate diagnosis of Multiple Sclerosis.

All participants were given either CME or CEU credit for the training and we collected evaluations from 72% of the participants. When asking the participants, “Will the course information be useful to your work”, on a scale of one to five, one (1) being “Absolutely” and five (5) being “Absolutely Not” the average response was a 1.7. The lecturer also stayed and did a half day hands on training with our behavioral health providers.

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

Achievement Value 1.00

Category 2: Integrate Physical and Behavioral Health Care

Process Milestone: Co-locate behavioral health and primary care, as measured by at least 2 behavioral health providers in primary care clinics.

(insert milestone)

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

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

Achievement: Yes

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

In an effort to integrate physical and behavioral health, we have implemented AUDIT-C screening in our Family Medicine clinic and have co-located two behavioral health providers at this location, a Certified Alcohol and Drug Counselor-II and a Licensed Marriage and Family Therapist. At registration, patients are given a five question alcohol and drug use questionnaire to complete. Questions 1 – 3 address frequency of alcohol use and questions 4 – 5 address frequency of drug use; both range from 0 – 6. A man who scores a 5 and a woman who scores a 4 would be considered a positive screen. The highest score possible is a 24. Nursing staff forward the questionnaires to the Behavioral Health Integration staff. Behavioral Health Integration staff review the questionnaires and flag those with high scores. They contact the patients to offer substance abuse services, including further assessment and evaluation, to determine the level of services needed. Patients will either: 1) Meet with BH staff for one brief encounter; 2) Meet with BH staff for a series of follow up encounters; or 3) be referred to Kern County Mental Health – GATE Team for more intense substance abuse services/treatment.

The GATE Team provides assessment and placement of individuals referred for notable substance abuse problems including co-occurring disorders. There is no charge for the assessment and referral. Additionally, in December 2011, KMC implemented a screening process for all patients admitted to the hospital. During intake, patients are asked about their alcohol and drug use/abuse. If they have a positive screen, a consult is automatically sent to the GATE team representative. The GATE team representative meets with the patient on the inpatient floor to complete an assessment and screen for appropriate services. We feel this inpatient screening is vital for coordinating services prior to a patients discharge from the hospital.

The Family Practice clinic had to consider multiple things when placing the behavioral health staff in Family Practice. They had to arrange for office space, schedules, patient flow, documentation, etc. Originally the behavioral health staff was given offices in the back of the clinic but this restricted easy conversation with the providers/residents regarding patients, as well as restricting “water cooler” conversations, interactions and opportunities for education. As a result, the behavioral health staff was moved to the middle of the clinic to allow for informal conversations and meetings with the providers and residents. They also saw an increase in the number of patients they were able to perform brief interventions with.

Next steps for the integration project are to start PHQ-9 and GAD-7 screenings. The PHQ-9 is a nine item depression scale that assists providers with diagnosing depression, keeping track of a patients overall depression severity, monitoring treatment response, and more specifically symptoms that are improving or not with treatment. Generalized Anxiety Disorder 7 (GAD-7) is a self-reported questionnaire for screening and severity measuring of generalized anxiety disorder.

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

Achievement Value 1.00

Category 2: Integrate Physical and Behavioral Health Care

Process Milestone: Development of a tracking mechanism of referrals from primary care providers to on-site behavioral health professionals.

(insert milestone)

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

The Behavioral Health Project Manager and Behavioral Health Coordinator met with all KMC and Kern County Mental Health (KCMH) stakeholders to develop and implement a tracking mechanism for all mental health referrals. A policy was drafted and vetted for review by all stakeholders. Referrals are tracked through KMC's electronic medical record and the KCMH's Anasazi system. Additionally, we have reporting metrics that are shared monthly with a larger stakeholder group which include the following metrics:
1. Number of referrals and from which primary care providers
2. Number of Crisis Inpatient Referrals for PEC, 3B and Inpatient Psychiatric Unit (IPU)
3. Number of patients in group therapy
4. Total clients assessed
5. Average days from referral to assessment
6. Average days/time for completing assessment
7. Disposition of referrals: treatment or refer back to PCP

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

DSRIP Semi-Annual Reporting Form

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

REPORTING ON THIS PROJECT: * Yes

Category 2: Establish/Expand a Patient Care Navigation Program

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

DY Total Computable Incentive Amount: * $ 4,837,443.90

Incentive Funding Already Received in DY: * $ 3,628,082.93

Process Milestone: Increase patient engagement, by completing 5 patient engagement initiatives.
(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

Five Patient Engagement Initiatives:
1) Redesign Patient Guide: KMC's patient guide was old and lacking valuable information for patients. We formed a committee to evaluate the current patient guide and develop the content for a new patient guide, which provides information about KMC's hospital services, financial information, privacy rights, outpatient/discharge information, health education, etc. The committee went through a three month review process and approved the final draft of the guide in December. The guide will be printed in English and Spanish and provided to all patients admitted in the hospital.

KMC will evaluate the success of this initiative by asking patients focused questions regarding the Patient Guide during Administrative Rounds each day. KMC's Chief Nursing Officer and Chief Medical Officer complete Administrative Rounds on the inpatient floors each day to speak to patients and ask focused questions about changes that have been implemented, as well as the patient's overall satisfaction and experience with their stay at KMC.

2) Hospital Campus Map and Sign Redesign Project: In an effort to better guide patients around the hospital campus, KMC partnered with Bakersfield College's graphic design department and had new campus maps created for patients, as well as, new signs to better guide patients around the hospital campus. The signs have now been in place for approximately 6 months and Administration has received various tips and suggestions for further changes. In the coming months, additional signage will be added to select areas of the hospital in order to provide more information on the first floor as to where to find certain clinics and offices on the other floors of the hospital. In order to test the usefulness of the signs, our Chief Operating Officer plans to provide a number of random non-staff volunteers a list of hospital locations they need to reach using hospital signage only. The COO proposed giving the volunteers cafeteria coupons for time.

3) Physical and Behavioral Health Integration Initiative: This initiative created a Physical and Behavioral Health Integration Committee, composed of county experts, key stakeholders, and primary care, mental health and substance abuse providers that would convene with the goal of creating an opportunity for collaboration, integration, coordination and continuity of care for patients transitioning between both systems. As a committee, we developed our own definition of Integration, a mission, purpose and focus areas.

Definition of Integration: A system that is accountable for coordination, communication and access to physical health, mental health and substance use disorder services.

Mission: Through the use of patient centered and integrated physical health, mental health and substance use disorder services, we will improve the quality of life for all patients.

Purpose 1) Improve quality care and patient outcomes; 2) The right provider, the right time, for the right reason; 3) Resident, provider and patient teaching opportunity; and 4) Introduction to interdisciplinary team approach.

Category 2: Establish/Expand a Patient Care Navigation Program

Focus Areas: 1) Screening; 2) Care Coordination; 3) Communication; 4) Treatment; 5) Training and 6) Prevention

Various evaluations techniques will be used by this initiative, including: chart reviews, training evaluations, provider interviews/surveys, patient satisfaction surveys and referral stats.

4) Launched the Patient Experience Transformation (PExT) Initiative: The PExT Initiative is a partnership of leaders and staff from California public hospital systems, the California Health Care Safety Net Institute (SNI), and nationally-recognized patient experience experts at ExperiaHealth that aims to help California public hospitals measure, understand and improve their patients' experience of care. KMC attends monthly webinars, attends off-site conferences and holds a local quarterly PExT Initiative Committee meeting. KMC has also identified our Chief Medical Officer has our "Chief Experience Officer", leading this initiative. Furthermore, at the Annual Medical Staff Meeting, the guest speaker was Dr. Susan Stangl, Associate Clinical Professor at UCLA. She is a Family Medicine physician who developed a curriculum for teaching medical students "Interpersonal Skills" and has many workshops on the subject. Additionally, she conducts workshops in doctor-patient communications and improving patient satisfaction for all newly hired clinicians and clinicians with poor patient satisfaction scores.
KMC has also focused on mid-management training on patient experience and customer service.
Evaluation techniques that will be used for this initiative will include but not be limited to: daily Administration Rounds, patient satisfaction scores and trends in grievances.
5) In the Spring of 2012, KMC implemented an Information Desk and greeter at the KMC Primary Care location. The greeter is stationed at the information desk from 8AM to 3PM Monday through Friday and is responsible for directing patients to various clinic locations; greeting all patients when they enter the facility; helping individuals with wheelchairs, baby strollers, walkers, crutches, etc. Additionally, many of the waiting areas had no televisions or means of entertaining patients while they were waiting for their appointment. So KMC worked with Accent Health, a Health Education TV Network to install six health education TVs in different waiting rooms to focus on preventive care and self-management tips. Accent Health is chosen by over 41,000 practitioners nationwide and is in more than 12,000 medical sites. Since the installation of the TVs and implementation of the greeter, we have not only had patients but staff says how happy they are with the changes. We will continue to monitor patient and staff feedback regarding this initiative.

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

Category 2: Establish/Expand a Patient Care Navigation Program

Process Milestone: Expand program to include ED Navigator, who educates patients on importance of primary care; connects patients to a new Primary Care Clinic and/or assists patient in getting following appointment with established PCP.

(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

Patients are often most at risk of facing difficulty navigating the health care system once they leave the emergency department. Patients often present to the ED for non-urgent conditions that could have been treated in a primary care setting. Although estimates vary, up to 49% of emergency department visits are for avoidable causes. To help patients better navigate the system, we hired an ED Care Coordinator. The ED Care Coordinator educates patients about the importance of primary care, as well as, coordinates with other community clinics and the county primary clinics to provide appointment slots that can be given to the patient upon discharge from the emergency department.

All policies and training materials were completed for the ED Navigator Program and the ED Care Coordinator was hired in December 2011.

KMC will monitor the following:
• Percent of patient seen by the EDCC while the EDCC was working
• Number of appointment slots provided by each community clinic
• Number of patients without a primary care provider who received education about a primary care provider in the ED
• Number of patients without a primary care provider who were referred to a primary care provider in the ED
• Number of patients without a primary care provider who are given a scheduled primary care provider appointment
• Number of patients with a primary care provider who are given a scheduled primary care provider appointment
• Number of patients referred for financial screening and/or KMCHP application started in ED
KMC plans to evaluate the impact of program on IP/ER utilization: Quarterly, request list of all ER visits for that quarter and flag patients who have received some level of EDCC intervention. Compare rates of:
o ER re-utilization
o ER re-use within 72 hours of last visit
o IP admissions

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

Achievement Value 1.00

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

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

Below is the data reported for the DPH system.
* *Instructions for DPH systems: Please type in all of your DY milestones for the project below and report data in the indicated boxes (*). Note: for DY8, data from the last 2 quarters shall suffice.*

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

Patient/Care Giver Experience (required)

DY Total Computable Incentive Amount:	* $ 2,413,125.00
Incentive Funding Already Received in DY:	* $ 1,206,562.50

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

A positive patient/caregiver experience is essential, especially in the outpatient setting, for its ability to impact both quality and cost of care. Research indicates that increased satisfaction and improved communication between providers and patients has been shown to increase compliance with treatment plans, especially among patients with chronic diseases.

After much research, multiple vendor presentations and various quotes, KMC selected to contract with Press Ganey as our CGCAHPS and HCAHPS vendor moving forward. KMC is positioning themselves for the best outcome and product by contracting with Press Ganey.

- Besides home-grown non-vendor models, Press Ganey is the most widely used vendor among California Public Hospital systems and academic facilities like KMC.
- Under DSRIP, KMC must follow common survey mode/type, sampling, aggregation and reporting protocols defined by DHCS. These protocols are unique and specific to California Public Hospitals. It will be required that a vendor not only meets these requirements but fully understand the risks, protocols and timelines set forth by DHCS in DSRIP.
- The American Medical Group Association (AMGA) has selected Press Ganey as its official collaborator for its Accountable Care Organization (ACO) patient experience surveying and improvement services.
- Press Ganey has the largest database of all vendors with over 100,000 Physicians in our CGCAHPS database. NRC and other do not even have half that. This is very important to gain accurate benchmarking.

Also, in additional the existing inpatient, emergency department and home health surveys already in place at KMC, we expanded our contract to not only include outpatient clinics, but radiology, lab, diagnostic imagining and all therapies, as well.

The vendor contract was approved by the Kern County Board of Supervisors on March 27, 2012. KMC worked with the vendor during April through June to implement all surveys. Provider/Staff information and training on online tools also starting during this time.

Achievement	Yes
Achievement Value	1.00

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

Category 3: Care Coordination *(required)*

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

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The black boxes indicate Milestones and will automatically populate and flow to summary sheets
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Care Coordination (required)

DY Total Computable Incentive Amount:	*	$ 2,413,125.00
Incentive Funding Already Received in DY:	*	$ 1,206,562.50

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

Data Collection Source	*	Data warehouse
Numerator	*	9.0
Denominator	*	2,469.0
Rate		0.4

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):

KMC did multiple rounds of communication to the KMC Medical Executive Committee, Quality Council and Physician Board of Governors regarding the DSRIP Category 3 Measures being collected. Additionally, we worked closely with our Information Systems staff and data analysts team to maximize the data being pulled from the various KMC systems. For the diabetes indicators we pull information from our outpatient practice management system, as well as our hospital billing system. Then we created a detailed crosswalk and matching of data elements to store data in a separate table for maximum querying ability. KMC is working on interfacing all three of these systems to our disease registry so future reporting can be pulled from this system.

KMC had 2,469 diabetic patients, age 18-75 years who have visited our primary care clinics two or more times in the prior demonstration year. Of those 2,469 patients, 9 patients were admitted with an ICD-9 principal diagnosis code for short-term complications within the demonstration year reporting period.

Since there are 4 diabetic indicators within the DY7 Category 3 measure set, KMC has provided an overall diabetic management plan below. This summary will be consistent for the following measures: Diabetes, short team complications, Uncontrolled Diabetes, Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (< 100 mg/dL), and Diabetes Mellitus: Hemoglobin A1c Control (<8).

According to state public health data, Kern County currently ranks 57 out of 58 California counties in diabetes-related deaths , indicating a need for much improved diabetes management. In addition, in an analysis of ambulatory care sensitive conditions (ACS) of admissions in 2008, diabetes-related complications resulted in the highest cost ACS admissions to KMC. ACS conditions are conditions for which patients were admitted, but could have been prevented or avoided through timely outpatient care. To address this issue, KMC is in the process of implementing a new diabetes clinic to better manage the diabetic population of Kern County.

This clinic is in addition to the diabetic management done by the Primary Care Provider. Guidelines were created for referrals to diabetic education, endocrinology, podiatry and VPS or Ophthalmology for diabetic patients. Our local initiative has agreed to pay a facility fee per member per day for these services.

Most diabetics can be managed by the Primary Care Provider in the office with the goals of achieving:
• HgbA1C < 7.5

Category 3: Care Coordination *(required)*

- HgbA1C < 7.5
- LDL-C < 100
- BP </= 130/90
- Foot check at each visit, at least annually
- Yearly retinal exam

For the diabetes clinic, KMC plans to use a new model of care which is comprised of a multidisciplinary team and three different visit types.

- Initial Assessment team consists of a Clinical Pharmacists, RN/Diabetic Educator, Dietitian, Physical Therapist and medical assistant
- Follow-up Visits team consist of a Clinical Pharmacists, RN/Diabetic Educator and Dietitian
- Group Education team consists of a Clinical Pharmacists, RN/Diabetic Educator, Dietitian and Exercise Physiologist

Diabetic education will be used:

- At time of diagnosis
- When patient unable to achieve glycemic goals
- When patient needs more education on self-management of diabetes and on the importance of achieving glycemic control
- Gestational diabetes

Furthermore, to inform providers' care plans for patients and ensure that patients are provided with appropriate reminders, KMC's newly implemented disease registry is critical in providing access to timely and relevant individual data. Moreover, the disease registry can serve as an important tool to aggregate and summarize population data if it issued for all patients with the disease.

Achievement	Yes
Achievement Value	1.00

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

Data Collection Source	* Data warehouse
Numerator	* 3.0
Denominator	* 2,469.0
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):

KMC did multiple rounds of communication to the KMC Medical Executive Committee, Quality Council and Physician Board of Governors regarding the DSRIP Category 3 Measures being collected. Additionally, we worked closely with our Information Systems staff and data analysts team to maximize the data being pulled from the various KMC systems. For the diabetes indicators we pull information from our outpatient practice management system, as well as our hospital billing system. Then we created a detailed crosswalk and matching of data elements to store data in a separate table for maximum querying ability. KMC is working on interfacing all three of these systems to our disease registry so future reporting can be pulled from this system.

KMC had 2,469 diabetic patients, age 18-75 years who have visited our primary care clinics two or more times in the prior demonstration year. Of those 2,469 patients, 3 patients were admitted with an ICD-9 principal diagnosis code for uncontrolled diabetes within the demonstration year reporting period.

Since there are 4 diabetic indicators within the DY7 Category 3 measure set, KMC has provided an overall diabetic management plan below. This summary will be consistent for the following measures: Diabetes, short team complications, Uncontrolled Diabetes, Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (< 100 mg/dL), and Diabetes Mellitus: Hemoglobin A1c Control (<8).

According to state public health data, Kern County currently ranks 57 out of 58 California counties in diabetes-related deaths , indicating a need for much improved diabetes management. In addition, in an analysis of ambulatory care sensitive conditions (ACS) of admissions in 2008, diabetes-related complications resulted in the highest cost ACS admissions to KMC. ACS conditions are conditions for which patients were admitted, but could have been prevented or avoided through timely outpatient care. To address this issue, KMC is in the process of implementing a new diabetes clinic to better manage the diabetic population of Kern County.

Category 3: Care Coordination *(required)*

This clinic is in addition to the diabetic management done by the Primary Care Provider. Guidelines were created for referrals to diabetic education, endocrinology, podiatry and VPS or Ophthalmology for diabetic patients. Our local initiative has agreed to pay a facility fee per member per day for these services.

Most diabetics can be managed by the Primary Care Provider in the office with the goals of achieving:
• HgbA1C < 7.5
• LDL-C < 100
• BP </= 130/90
• Foot check at each visit, at least annually
• Yearly retinal exam

For the diabetes clinic, KMC plans to use a new model of care which is comprised of a multidisciplinary team and three different visit types.
• Initial Assessment team consists of a Clinical Pharmacists, RN/Diabetic Educator, Dietitian, Physical Therapist and medical assistant
• Follow-up Visits team consist of a Clinical Pharmacists, RN/Diabetic Educator and Dietitian
• Group Education team consists of a Clinical Pharmacists, RN/Diabetic Educator, Dietitian and Exercise Physiologist

Diabetic education will be used:
• At time of diagnosis
• When patient unable to achieve glycemic goals
• When patient needs more education on self-management of diabetes and on the importance of achieving glycemic control
• Gestational diabetes

Furthermore, to inform providers' care plans for patients and ensure that patients are provided with appropriate reminders, KMC's newly implemented disease registry is critical in providing access to timely and relevant individual data. Moreover, the disease registry can serve as an important tool to aggregate and summarize population data if it issued for all patients with the disease.

Achievement	Yes
Achievement Value	1.00

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

Category 3: Preventive Health *(required)*

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

* The yellow boxes indicate where the DPH system should input data
The black boxes indicate Milestones and will automatically populate and flow to summary sheets
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Preventive Health (required)

DY Total Computable Incentive Amount:	* $ 2,413,125.00
Incentive Funding Already Received in DY:	* $ 1,206,562.50

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

Data Collection Source	* Data warehouse
Numerator	* 932.0
Denominator	* 1,745.0
Rate	53.4

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):

KMC did multiple rounds of communication to the KMC Medical Executive Committee, Quality Council and Physician Board of Governors regarding the DSRIP Category 3 Measures being collected. Additionally, we worked closely with our Information Systems staff and data analysts team to maximize the data being pulled from the various KMC systems. For the mammography screening for breast cancer indicator we pull information from our outpatient practice management system, as well as our electronic medical record. Then we created a detailed crosswalk, matching data elements from both systems to store data in a separate table for maximum querying ability.

KMC had 1,745 female patients age 50-74 years that visited our primary care clinics two or more times in the prior demonstration year. Of those 1,745 patients, 932 patients had a mammogram screen for breast cancer within 24 months. This equals a rate of 53.4% of patients. HEDIS 2009 (age 40-69) benchmark for commercial plans is 71% and for Medicaid 52%; therefore, KMC is above Medicaid benchmarks but below commercial plan.
One limitation to this data is if the patient received their mammography screen outside KMC campus, this information is only being stored in a note within the patient's medical record and therefore, not being stored in a reportable field. So in the coming months, KMC will be working with our IS team and EMR analyst to develop what is called a dialog. The dialog will be used to store a health factor in the patient's medical record, which will allow us to report off the data. The dialog option will be implemented for a number of Category 3 measures.

Between the measurement periods of 2005-2009 Kern County had 115.3 cases of breast cancer per 100,000 females. In comparison to other U.S. counties, Kern is within the top 50th percentile. Other DSRIP projects that will help us focus on mammography screening is the implementation of our disease registry and our focus on population management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care. Under this initiative, KMC won't only focus on breast cancer screenings but colon and cervical cancer screenings as well.

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 *	Data warehouse
Numerator *	747.0
Denominator *	3,250.0
Rate	23.0

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

KMC did multiple rounds of communication to the KMC Medical Executive Committee, Quality Council and Physician Board of Governors regarding the DSRIP Category 3 Measures being collected. Additionally, we worked closely with our Information Systems staff and data analysts team to maximize the data being pulled from the various KMC systems. For the influenza immunization we pulled information from our outpatient practice management system, as well as hospital billing system. Then we created a detailed crosswalk, matching data elements from both systems to store data in a separate table for maximum querying ability.

KMC had 3,250 patients 50 and older that visited our primary care clinics two or more times in the prior demonstration year. Of those 3,250 patients, 747 patients had an influenza immunization during the flu season (September through February) of the current demonstration year. This equals a rate of 23% of patients. HEDIS 2009 benchmark for commercial plans (age 50-64) is 51%; therefore, KMC is below commercial plan benchmarks.
KMC did a number of things to encourage patients to get influenza immunizations. First, KMC implemented a hospital wide public relations campaign, hanging flyers in clinics, elevators, etc. with the benefits of getting an influenza immunization. Secondly, KMC included information for where patients can get an influenza immunization, including multiple public health clinic locations around Kern County. Lastly, KMC hosted our own Flu Shot clinic, which ran in the evenings to provide influenza immunizations to KMC patients at no cost. Even with all of these initiatives, KMC was only able to identify 23% of patients within the specified age population as having had an influenza immunization. There are multiple factors that could be contributing to this low rate: 1) patients received their influenza immunization outside KMC campus (public health clinic, employer, etc) and therefore reporting is difficult; 2) KMC targeted all appropriate influenza immunization age groups for the flu shot and didn't single out the 50 and older group for more targeted outreach; 3) poor documentation took place during the flu shot clinic where documentation was scanned into the patient's medical record but not keyed into a reportable field; and 4) flu shot was given outside the September to February time period. KMC is looking into all of these issues to increase our flu shot rate for patients 50 or older.
As described in the mammography screening narrative, KMC will implement a dialog box for capturing influenza immunization information, which will create a reportable health factor on the patient's medical record. Once the interface between our disease registry and EMR is complete, KMC will be able to use the disease registry to target patients that are 50 or older, who have not had their influenza immunization. KMC will also use the disease registry to target other applicable patient populations in need of an influenza immunization.

Achievement	Yes
Achievement Value	1.00

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

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

Below is the data reported for the DPH system.

* *Instructions for DPH systems: Please type in all of your DY milestones for the project below and report data in the indicated boxes (*). For the last two measures, which are both diabetes composite measures, please follow the instructions on specifically how to calculate the composite measures (available based on NQF endorsement).*

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

At-Risk Populations (required)

DY Total Computable Incentive Amount:	* $ 2,413,125.00
Incentive Funding Already Received in DY:	* $ 1,206,562.50

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

Data Collection Source	* Electronic medical record (EMR)
Numerator	* 938.0
Denominator	* 2,469.0
Rate	38.0

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

KMC did multiple rounds of communication to the KMC Medical Executive Committee, Quality Council and Physician Board of Governors regarding the DSRIP Category 3 Measures being collected. Additionally, we worked closely with our Information Systems staff and data analysts team to maximize the data being pulled from the various KMC systems. For the "At Risk Population" diabetes indicators we pulled information from our outpatient practice management system, hospital billing system and electronic medical record. Then we created a detailed crosswalk and matching of data elements to store data in a separate table for maximum querying ability. KMC is working on interfacing all three of these systems to our disease registry so future reporting can be pulled from this system.

KMC had 2,469 diabetic patients, age 18-75 years who have visited our primary care clinics two or more times in the prior demonstration year. Of those 2,469 patients, 938 patients had a LDL-C level in control (less than 100 mg/dl) within the demonstration year reporting period. This equals a rate of 38%. HEDIS (2009) benchmark for commercial plans is 47% and Medicaid is 33.5%; therefore, KMC is above Medicaid benchmarks but below commercial plan.

Refer to Category 3 Care Coordination tab for a detailed explanation of KMC's diabetes management plan moving forward.

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	*	1,097.0
Denominator	*	2,469.0
Rate		44.4

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):

KMC did multiple rounds of communication to the KMC Medical Executive Committee, Quality Council and Physician Board of Governors regarding the DSRIP Category 3 Measures being collected. Additionally, we worked closely with our Information Systems staff and data analysts team to maximize the data being pulled from the various KMC systems. For the “At Risk Population” diabetes indicators we pulled information from our outpatient practice management system, hospital billing system and electronic medical record. Then we created a detailed crosswalk and matching of data elements to store data in a separate table for maximum querying ability. KMC is working on interfacing all three of these systems to our disease registry so future reporting can be pulled from this system.

KMC had 2,469 diabetic patients, age 18-75 years who have visited our primary care clinics two or more times in the prior demonstration year. Of those 2,469 patients, 1,097 patients had a Hemoglobin A1c in control (<8%) within the demonstration year reporting period. This equals a rate of 44.4%.

Refer to Category 3 Care Coordination tab for a detailed explanation of KMC's diabetes management plan moving forward.

Achievement	Yes
Achievement Value	1.00

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Kern Medical Center
REPORTING YEAR: DY7
DATE OF SUBMISSION: 9/30/2012

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

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

Severe Sepsis Detection and Management

DY Total Computable Incentive Amount:	* $ 1,512,500.00
Incentive Funding Already Received in DY:	* $ 1,260,416.67

Compliance with Sepsis Resuscitation bundle (%)

Numerator	* 101
Denominator	* 169
% Compliance	0.60

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

The timeframe for numerator and demoninator is July 2011 thru June 2012. With Kern Medical Center's (KMC) original submission for sepsis bundle compliance was 12/31/12, The organization was instructed through phone conversations with SNI to follow the specifications without any exclusions to include patients with simple sepsis with no sign of organ dysfuncation. This caused issues in reports as patients with simple sepsis do not require bundle implementation. We later deteremined that other hospitals in the DSRIP project were removing this population set from their audits. After discussions occurred related to Sepsis specification between SNI, DHCS and CMS it was communicated to DSRIP hospitals that changes were made to the data collection requirements. This however made our data that was already submitted in the first Semi Annual report incorrect. In addition, it was discovered that the data requiriement for the SNI collaborative and DSRIP reporting, regarding fluid resuscitation, was different (1 hour per SNI and 6 hours for DSRIP) as well. This caused confusion and we discovered that our data collection team was auditing for DSRIP using the 1 hour fluid resuscitation requirment and not the DSRIP 6 hour requirment. This skewed our data. After discussion with the SNI and Special Assistant to the Medical Director of DHCS we have made the correction to all 12 months of our data which we are submitting in this report. We are providing this explaination of our correction at the direction of Special Assistant to the Medical Director of DHCS. Kern Medical Center has developed auditing tools and processes to collect data in real time and provide feedback to staff on performance. We have submitted 9 months of Sepsis Bundle complianice for baseline data to Safety Net Insititute(SNI). Kern Medical Center is working with SNI to establish our Sepsis Resuscitation Bundles baseline and benchmarks for DY8 reporting. Mortality rate will be reported in DY8 as set forth in our plan. The KMC multidisiciplinary team implemented the Sepsis Bundle during DY7 using the "P-D-C-A" methodology. The team met bi-weekly. The team developed and provided Sepsis education for clincal staff and Medical Staff. The team developed and implemented a sepsis assessment tool with standardized labs which is completed every 12 hours by nursing to assist in early identification of severe sepsis. This tool is used in the ED, ICU/DOU, Med/Surg, and Obstetric units. This sepsis bundle has been incoporated into the "rapid response" team protocols. The team is working through a dedicated RN who gives feedback on individual performance in realtime ,with both frontline clincial staff and the medical staff to improve compliance.

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

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

Optional Milestone: 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

Sepsis multidisciplinary team met biweekly July 2012 through June 2012. The following was completed for DY7: 1) a gap analysis of current processes for detecting and treating severe sepsis with completion of written report. Gap Analysis was completed in July/August of 2011. The multidisciplinary team flow-charted the current sepsis process in the following areas ED, ICU/DOU and Medical/Surgical for assessment/identification, treatment and disposition of patients. The current process of each area was evaluated against best practice (per literature search e.g. IHI, American Heart Association; Patient Safety First) to determined the changes needed for the sepsis process. Changes identified and then made using the P-D-C-A methodology were: a) Need to development a risk assessment tool for early identification of sepsis; b) Need to development a treatment protocol with physician orders set in the Electronic Medical Record (EMR) for consistent implementation of sepsis treatment; c) Need to implement a complete sepsis bundle within 6 hours timeframe; d) Need to move septic patient from ED to ICU in 4 hours after admit orders and transfer medical surgical patient to ICU within 1 hour; e) need to provide education and training to staff and medical staff on assessment and treatment protocol for sepsis; 2) Developed a formalized interprofessional “Severe Sepsis Treatment Protocol” with physician order set placed in EMR and approved policy and procedure; 3) Participated in all scheduled collaborative meetings/webinars over the past 12 months for the time period July 1, 2011 - June 30, 2012 with required submission of data per collaborative schedule; 4) Developed/completed Severe Sepsis education of licensed RN/LVN and Medical Staff faculty. As of June 2012 539/594 = 91% have completed education. Goal 85%. Sepsis education was completed September - October 2011 for RN staff. Goals and objective: a) Describe the difference between Sepsis, Severe Sepsis, and Septic Shock; b) Identify signs and symptoms of systemic inflammatory response syndrome (SIRS); c) Discuss assessment findings correlated with patients who are at increased risk for sepsis (Index of Suspicion); d) Identify signs and symptoms of organ dysfunction; e) Identify the six goals of the Sepsis Resuscitation Bundle, and key interventions to reach goal; f) Effectively use the Severe Sepsis Screening Tool and Sepsis Resuscitation and Management Bundle Protocol. Education outline: a) Overview of Sepsis; b) Epidemiology; c) Sepsis mortality; d) Define sepsis vs. severe sepsis; e) Sepsis clinical signs and symptoms f) Sepsis Resuscitation bundle; g) Sepsis Management bundle; h) Sepsis screening tool and i) completion of 4 case studies. Staff completed pretest and post-test. Medical Staff (MS) received education at MS staff meetings covering the above material. Effectiveness of education was evaluated with through data collection: 1) staff knowledge of completeness sepsis tool; 2) compliance with accuracy of sepsis assessment; and 3) compliance with implementation of sepsis bundle. Education is ongoing.

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

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Kern Medical Center
REPORTING YEAR: DY7
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
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Central Line Associated Blood Stream Infection

DY Total Computable Incentive Amount:	* $ 1,512,500.00
Incentive Funding Already Received in DY:	* $ 1,260,416.67

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

Numerator	* 201.00
Denominator	* 219.00
% Compliance	0.92

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):

Time frame for numerator and denominator is July 2011 thru June 2012. The team with the assistance of designated RN Staff Kern Medical Center has developed auditing tools and processes to collect data in real time and provide feedback in realtime to both frontline clincial staff and the medical staff to improve CLIP compliance. Kern Medical Center has submitted 12 months of baseline data to Safety Net Insititute(SNI). Kern Medical Center is working with SNI to establish our CLABSI baseline and set our benchmarks for DY8 reporting. The multidiciplinary team developed and implemented a standardized central line kits/carts, identification process for central lines placed under emergent situations to allow for reinsertion within 48 per bundle, standardized central line protocol/physician order in EMR, CLIP bundle.

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: 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

CLABSI multidiciplinary team met biweekly July 2011 thru June 2012. The following was completed:1) gap analysis of our current processes for inserting/maintaining central lines with report completed July/August 2011. The munltidisciplinary team flow charted the CLIP process for the following areas: ED, ICU,DOU, Medical/Surgical floors. The current process of each areas was evaluated against best practice (per literature search e.g. CDC, IHI, NHSN, Patient Safery First Collaborative) to determined the changes needed on CLIP/CLABSI processes. The following areas were identified for improvement: a) Need for standardized process for obtaining form; b) Need for standardized process on medical/surgical floors for notification of procedures to ensure CILP practices and forms are completed; c) Consistant documentation of dressing and tubing changes as well as daily medical necessity; d) Standardized supplies and kits on all units that perform procedures; e) Consistant patient education; f) Development of standardized checklist for supplies for performing central line insertion; 2) Development of a formalized inter-professional "Central-line Treatment Protocol" with physician order set placed on Electronic Medical Record and revision of policy and procedure;3) Participated in all scheduled collaborative meetings/ webinars over past 12 months July 1, 2011 - June 30, 2012, with required submission of data per collaborative schedule.4) Developed and completed CLIP and CLABSI education for both licensed RN/LN staff and Medical Staff faculty. As of June 2012 721/745 =97% have completed education. Goal is 85%. Education is ongoing. Education: Goals and Objectives: 1) Understand physiology of Central Line-Associated Bloodstream Infections (CLABSI); 2) Knowledge of the CLABSI Bundle; 3) Differentiate between types of lines; 4) Knowledge of new Central Venous Catheter Policy; 5) Recognize your role in preventing infection; 6) Knowledge of the CLIP's form and Denominator Data. Outline: 1)Bloodstream infeciton/Identification of CLABSI; 2) Healthcare-associated infection facts; 3) IHI improvement; 4) What is a bundle; 5) Central Line Bundle Elements; 6) Hand Hygiene; 7) Maximal Barrier Precautions Upon Insertion; 8) CHG Antisepsis/Bundle Element; 9) optimal Catheter Site Selection; 10) Daily Review of Central Line Necessity with Prompt Removal; Thinking Outsde the Bundle - CDC Guidelines; 11) Central Venous Catheters; 12) Types of Central Lines; 13) Infection Control Practices for Provider; 14) Infection Control Practices for RN; 15) Central-line Practices; 16) Central Line Maintenance; Central Line Removal and Patient Care; 17) CLIP form documentation; Central-LineTracking. Staff completed pretest and post-test. Medical Staff received education at staff meetings covering the above material. Effectiveness of education is evaluated through 1) staff knowledge, and 2)compliance with CLIP practices.

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

Achievement Value 1.00

Optional Milestone: Report at least 6 months of data collection on 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

Twelve (12) months of CLIP and CLABSI data for time period June 2010 thru July 2011 was submitted to Safety Net Iinstitude on July 31, 2012, as requested by DHCS. As reported to SNI: CLIP compliance - 101/112= 90%; and CLABSI rate 12/7157= 1.68. A KMC multidisiciplinary team implemented the CLABSI Bundle during DY7 using the "P-D-C-A" methodology. The team met bi-weekly. The multidisciplinary team developed and provided CLABSI education for clincal and medical staff. The team developed and implemented a standardized central line kits/carts, identification process for central lines placed under emergent situations to allow for reinsertion within 48 per bundle, standardized central line protocol/physician order in EMR. The team worked wtih a designated RN who gives feedback on individual performance in realtime ,with both frontline clincial staff and the medical staff to improve CLIP compliance.

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

Achievement Value 1.00

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Kern Medical Center
REPORTING YEAR: DY7
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 (*).*

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Hospital-Acquired Pressure Ulcer Prevention

DY Total Computable Incentive Amount:	* $ 1,512,500.00
Incentive Funding Already Received in DY:	* $ 1,134,375.00

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

Numerator	* 29.00
Denominator	* 895.00
Prevalence (%)	0.03

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):

Timeframe for numerator and denominator is July 2011 - June 2011. Kern Medical Center (KMC) reviewed our data for HAPU prevalence for HAPU stage 2 and greater using CALNOC Prevalence studies from April 2010 to March 2011. The data showed an inconsistent rate with the combined unit (Critical Care, Medical/ Surgical and Step Down) at 7.0. for the last qtr. In addition, it was noted that KMC had an increase in required reportable HAPU to CDPH. KMC determined that a goal of 5.5% in DY8 and 3.2% DY9 would allow the organization to reach the goal of 1.1 in DY10. The team increase HAPU prevalence surveillance from quarterly to monthly. The HAPU prevalence rate for July – September 2011 was 5.3; October – December 2011 was 5.6; January –March 2012 was 3; April – June 2012 was .4; with overall rate for year the fiscal year was 3.2%. The team completed the following to improve our rate from 7.1 to 3.2: 1) A gap analysis was completed in July/August 2011. The multidisciplinary team flow charted the current skin care assessment and treatment process in the following areas ICU, Step Down (DOU), and Medical/Surgical. The current process of each areas was evaluated against best practice (per literature search e.g. IHI, AHRQ, AORN, WOC) to determined the changes needed in skin care assessment and treatment process. The following areas were identified for improvement with changes implemented using the P-D-C-A methodology: a) Inconsistent communication on consults for skin at time of transfer to another unit; b) Patients not consistently on the appropriate bed surface at time of admission or when transferred. c) Patient plan of care not consistently modified to include wounds as needed; d) standardized orders did not consistantly tranfer in the EMR when transferring a patient to higher level of care; e) assessment of skin was not consistent from shift to shift. 2) Education was provided for RN staff. Goals and objectives were: a) Identify risks of pressure ulcer development; b) Improved understanding of the science behind the Braden Scale; c) Better understanding of why we need to identify a patients risk; d) Discuss interventions per KMC policy for pressure ulcer prevention; e) Accurately score patient risk using the Braden Scale. Education outline: a) Reliability of Braden scale; b) Accurately using Braden scale for patient risk determination; c) Skin care tips d) Documentation of assessment and plan of care. As of June 2012, 605/679 = 96% have completed education. Goal is 85%. Staff completed pretest and post-test. Medical Staff received education at staff meetings covering the above material. Effectiveness of education is evaluated through 1) staff knowledge; 2)compliance with skin assessment/Braden Scale ;3) HAPU prevalence rate. In addition, the team with the assistance of designated RN Staff Kern Medical Center developed auditing tools and processes to collect data in real time and provide feedback and education to staff on performance. DY 8 target is 5.5% as set forth in our plan.

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: Share data, promising practice, and finding 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

Kern Medical Center submitted data , promising practicies and findings to SNI on December 22, 2011. Kern Medical Center shared 12 issues that we had experienced with the promising practicies implemented to improve patient safety and quality of care. To highlight a few of the promising practices the organization has implemented new products, equipment (i.e. beds) , policy revisions to keep current with best practice, implentation of skin champions to increase expertise in the organization, education for licensed and nursing attendant, increase prevalence studies (monthly), implentation of standardized measurement routines, hourly rounding.

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

Achievement Value 1.00

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Kern Medical Center
REPORTING YEAR: DY7
DATE OF SUBMISSION: 9/30/2012

Category 4: Venous Thromboembolism (VTE) Prevention and Treatment

REPORTING ON THIS PROJECT: * Yes

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

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Venous Thromboembolism (VTE) Prevention and Treatment

DY Total Computable Incentive Amount: * $ 1,535,187.50

Incentive Funding Already Received in DY: * $ 1,279,322.92

Optional Milestone: Implement the VTE prevention program
(insert milestone)

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

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

Achievement: Yes

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

VTE multidisciplinary team met biweekly July 2011 thru June 2012 . The following was completed: 1) gap analysis of our current processes for assessment and prophylactic treatment with report. Gap Analysis was completed in July/August of 2011. The multidisciplinary team flow charted the current VTE process in the following areas ED, Pre-OP, PACU and Medical/Surgical for VTE assessment and treatment of confirmed VTE patients. The current process of each areas was evaluated against best practice (per literature search e.g. IHI, AHRQ, AORN) to determined the changes needed on VTE process. Changes identified and then made using the P-D-C-A methodology were: a) No current standardized procedure for VTE; b) Interventions that are ordered for "at risk" patients are not consistently being carried out in a timely manner; c) development of treatment protocol with physician orders set for consistent implementation of VTE prophylaxis/ confirmed VTE treatment; d) in consistant physicians documentation of risk assessent in the medical record; e) education is needed for documenting implementation of interventions.; 2) Developed a formalized inter-professional VTE Prevention/Treatment Protocol with physician order set placed in Electronic Medical Record and revision of policy and procedure;3) Participated in all scheduled collaborative meetings/ webinars over past 12 months July 1, 2011 - June 30, 2012 with required submission of data per collaborative schedule. 4) Developed and completed VTE education for both licensed RN/LN staff and Medical Staff faculty. July 2011 through June 2012, 605/679 =89% have completed education. Goal is 85%. VTE education was completed September - October 2011 for RN staff. Goals and objectives: 1) Identify signs and symptoms of VTE; 2) Identify contradictions for VTE prophylaxis; 3) Identify the elements of VTE Prevention Protocol and key interventions to reach outcomes; 4) Effectively document VTE prophylaxis in EMR. Education outline: 1) VTE definitions; 2) VTE Mortality and Morbidity; 3) VTE facts; 4) VTE risks; 5) DVT Signs and Symptoms; 6) VTE Prophylaxis; 7) VTE Protocol and Treatment; 8) VTE documentation; and 9) VTE equipment. Staff completed pretest and post-test. Medical Staff received education at staff meetings covering the above material. Effectiveness of education is evaluated through data collection: 1) staff knowledge of VTE protocol and treatment; 2) compliance with VTE protocol; and 3) compliance with implementation and documentation of VTE prophylaxis and 4) compliance with VTE bundle for confirmed VTE. Education is ongoing.

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

Achievement Value 1.00

Category 4: Venous Thromboembolism (VTE) Prevention and Treatment

Optional Milestone: Report at least 6 months of data collection on VTE 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

Data reporting timeframe is July 2011 thru June 2012. The data team evaluated the EMR reports and determined a chart audit was required to provided accurate data. For July 2011 to December 2012 the team audited a hundred percent of charts which meet critera as set forth in VTE data specifications. Starting with January 2012 - June 2012 months, random audits were initiated for indicators "VTE Prophylasis", using the sampling methodology as set forth in the data specfification document and per DHCS conference call . For all other indicators all charts that meet criteria (100%) was audited . Results of DY7 monitoring: VTE Prophylaxis (%) 2115/2208 = 96%; Intensive Care unit VTE Prophylaxis (%) 382/387=99%; VTE patient with anticoagulation overlap therapy (%) 26/35=74%; VTE patients receiving unfractionated heparin with dosages/platelet count monitoring (%) 22/24=92%; VTE discharge instructions (%) 16/31 = 52%.

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