CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP

| | |
|---|---|
| * DPH SYSTEM: | Natividad Medical Center |
| * REPORTING YEAR: | DY 7 |
| * DATE OF SUBMISSION: | 9/230/2012 |

**Total Payment Amount**

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

| *Category 1 Projects - Incentive Funding Amounts* | |
|---|---|
| Expand Primary Care Capacity | |
| Increase Training of Primary Care Workforce | $ 555,000.00 |
| Implement and Utilize Disease Management Registry Functionality | |
| Enhance Interpretation Services and Culturally Competent Care | $ 333,000.00 |
| Collect Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities | |
| Enhance Urgent Medical Advice | |
| Introduce Telemedicine | |
| Enhance Coding and Documentation for Quality Data | |
| Develop Risk Stratification Capabilities/Functionalities | |
| Expand Specialty Care Capacity | |
| Enhance Performance Improvement and Reporting Capacity | |
| TOTAL CATEGORY 1 INCENTIVE PAYMENT: | $ 888,000.00 |
| *Category 2 Projects* | |
| Expand Medical Homes | |
| Expand Chronic Care Management Models | |
| Redesign Primary Care | |
| Redesign to Improve Patient Experience | $ 2,047,421.88 |
| Redesign for Cost Containment | |
| Integrate Physical and Behavioral Health Care | |
| Increase Specialty Care Access/Redesign Referral Process | |
| Establish/Expand a Patient Care Navigation Program | |
| Apply Process Improvement Methodology to Improve Quality/Efficiency | $ 1,091,958.33 |
| 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: | $ 3,139,380.21 |
| *Category 3 Domains* | |
| Patient/Care Giver Experience *(required)* | $ - |
| Care Coordination *(required)* | $ 545,634.50 |
| Preventive Health *(required)* | $ 545,634.50 |
| At-Risk Populations *(required)* | $ 446,428.00 |
| TOTAL CATEGORY 3 INCENTIVE PAYMENT: | $ 1,537,697.00 |
| *Category 4 Interventions* | |
| Severe Sepsis Detection and Management *(required)* | $ 201,666.67 |
| Central Line Associated Blood Stream Infection Prevention *(required)* | $ 226,875.00 |
| Surgical Site Infection Prevention | |
| Hospital-Acquired Pressure Ulcer Prevention | $ 151,250.00 |
| Stroke Management | |
| Venous Thromboembolism (VTE) Prevention and Treatment | $ 75,625.00 |
| Falls with Injury Prevention | |
| TOTAL CATEGORY 4 INCENTIVE PAYMENT: | $ 655,416.67 |
| *TOTAL INCENTIVE PAYMENT* | $ 6,220,493.88 |

# DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Natividad Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/230/2012

## 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*

**Increase Training of Primary Care Workforce**

| | | |
|---|---|---|
| Process Milestone: | Expand Family Medicine Training Program by recruiting two additional first year | No |
| *Achievement Value* | | - |
| Process Milestone: | Increase the number of primary care trainees by providing training to at least six | Yes |
| *Achievement Value* | | *1.00* |
| Process Milestone: | Increase the number of primary care trainees by completing new MOU with | Yes |
| *Achievement Value* | | *1.00* |
| Process Milestone: | | N/A |
| *Achievement Value* | | |
| Process Milestone: | | N/A |
| *Achievement Value* | | |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| DY Total Computable Incentive Amount: | | $ 3,330,000.00 |
| Total Sum of Achievement Values: | | 2.00 |
| Total Number of Milestones: | | 3.00 |
| Achievement Value Percentage: | | 67% |
| Eligible Incentive Funding Amount: | | $ 2,220,000.00 |
| Incentive Funding Already Received in DY: | | $ 1,665,000.00 |
| **Incentive Payment Amount:** | | $ 555,000.00 |

**Category 1 Summary Page**

**Enhance Interpretation Services and Culturally Competent Care**

| | | |
|---|---|---|
| Process Milestone: | Establish baseline data for number of encounters facilitated by qualified | Yes |
| *Achievement Value* | | *1.00* |
| Process Milestone: | Implement language access policies and procedures. | Yes |
| *Achievement Value* | | *1.00* |
| Process Milestone: | Expand the number of qualified healthcare interpreters by 100%. | Yes |
| *Achievement Value* | | *1.00* |
| Process Milestone: | Expand qualified health care interpretation technology to 10% of departments | Yes |
| *Achievement Value* | | *1.00* |
| Process Milestone: | Increase number of encounters facilitated by qualified healthcare interpreters to | Yes |
| *Achievement Value* | | *1.00* |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| DY Total Computable Incentive Amount: | | $ 3,330,000.00 |
| Total Sum of Achievement Values: | | 5.00 |
| Total Number of Milestones: | | 5.00 |
| Achievement Value Percentage: | | 100% |
| Eligible Incentive Funding Amount: | | $ 3,330,000.00 |
| Incentive Funding Already Received in DY: | | $ 2,997,000.00 |
| **Incentive Payment Amount:** | | $ 333,000.00 |

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Natividad Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/230/2012

## 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*

**Redesign to Improve Patient Experience**

| | | |
|---|---|---|
| Process Milestone: | Conduct focus groups in one targeted clinical area to establish the baseline | Yes |
| *Achievement Value* | | *1.00* |
| Process Milestone: | Develop regular organizational display of patient experience data and provide | Yes |
| *Achievement Value* | | *1.00* |
| Process Milestone: | Develop a staff education plan to integrate the patient experience into employee | Yes |
| *Achievement Value* | | *1.00* |
| Process Milestone: | Implement at least one organizational strategy that includes the patient in shared | 0.50 |
| *Achievement Value* | | *0.50* |
| Process Milestone: | | N/A |
| *Achievement Value* | | |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| DY Total Computable Incentive Amount: | | $ 3,275,875.00 |
| Total Sum of Achievement Values: | | 3.50 |
| Total Number of Milestones: | | 4.00 |
| Achievement Value Percentage: | | 88% |
| Eligible Incentive Funding Amount: | | $ 2,866,390.63 |
| Incentive Funding Already Received in DY: | | $ 818,968.75 |
| **Incentive Payment Amount:** | | $ 2,047,421.88 |

## Category 2 Summary Page

### Apply Process Improvement Methodology to Improve Quality/Efficiency

| | | |
|---|---|---|
| Process Milestone: | Train process improvement advisors/champions. | Yes |
| *Achievement Value* | | *1.00* |
| Process Milestone: | Convene training events conducted by designated process improvement trainers. | Yes |
| *Achievement Value* | | *1.00* |
| Process Milestone: | Target 1 specific workflows, processes or clinical areas to improve utilizing the | Yes |
| *Achievement Value* | | *1.00* |
| Process Milestone: | | N/A |
| *Achievement Value* | | |
| Process Milestone: | | N/A |
| *Achievement Value* | | |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| Improvement Milestone: | | N/A |
| *Achievement Value* | | |
| DY Total Computable Incentive Amount: | | $ 3,275,875.00 |
| Total Sum of Achievement Values: | | 3.00 |
| Total Number of Milestones: | | 3.00 |
| Achievement Value Percentage: | | 100% |
| Eligible Incentive Funding Amount: | | $ 3,275,875.00 |
| Incentive Funding Already Received in DY: | | $ 2,183,916.67 |
| **Incentive Payment Amount:** | | $ 1,091,958.33 |

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Natividad Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/230/2012

## Category 3 Summary Page

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

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

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

| ***Category 3 Domains*** | |
|---|---|
| **Patient/Care Giver Experience (required)** | |
| Undertake the necessary planning, redesign, translation, training and contract negotiations in order to implement CG-CAHPS in DY8 (DY7 only) | Yes |
| *Achievement Value* | 1.00 |
| Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme to the State (DY8-10) | N/A |
| *Achievement Value* | |
| Report results of CG CAHPS questions for "How Well Doctors Communicate With Patients" theme to the State (DY8-10) | N/A |
| *Achievement Value* | |
| Report results of CG CAHPS questions for "Helpful, Courteous, and Respectful Office Staff" theme to the State (DY8-10) | N/A |
| *Achievement Value* | |
| Report results of CG CAHPS questions for "Patients' Rating of the Doctor" theme to the State (DY8-10) | N/A |
| *Achievement Value* | |
| Report results of CG CAHPS questions for "Shared Decisionmaking" theme to the State (DY8-10) | N/A |
| *Achievement Value* | |
| DY Total Computable Incentive Amount: | $ 892,856.00 |
| Total Sum of Achievement Values: | 1.00 |
| Total Number of Milestones: | 1.00 |
| Achievement Value Percentage: | 100% |
| Eligible Incentive Funding Amount: | $ 892,856.00 |
| Incentive Funding Already Received in DY: | $ 892,856.00 |
| **Incentive Payment Amount:** | $ - |

## Category 3 Summary Page

### Care Coordination (required)

| | |
|---|---|
| Report results of the Diabetes, short-term complications measure to the State (DY7-10) | Yes |
| *Achievement Value* | 1.00 |
| Report results of the Uncontrolled Diabetes measure to the State (DY7-10) | Yes |
| *Achievement Value* | 1.00 |
| Report results of the Congestive Heart Failure measure to the State (DY8-10) | N/A |
| *Achievement Value* | |
| Report results of the Chronic Obstructive Pulmonary Disease measure to the State (DY8-10) | N/A |
| *Achievement Value* | |
| DY Total Computable Incentive Amount: | $ 1,091,269.00 |
| Total Sum of Achievement Values: | 2.00 |
| Total Number of Milestones: | 2.00 |
| Achievement Value Percentage: | 100% |
| Eligible Incentive Funding Amount: | $ 1,091,269.00 |
| Incentive Funding Already Received in DY: | $ 545,634.50 |
| **Incentive Payment Amount:** | $ 545,634.50 |

## 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* |
| Report results of the Child Weight Screening measure to the State (DY8-10) | N/A |
| *Achievement Value* | |
| Report results of the Pediatrics Body Mass Index (BMI) measure to the State (DY8-10) | N/A |
| *Achievement Value* | |
| Report results of the Tobacco Cessation measure to the State (DY8-10) | N/A |
| *Achievement Value* | |
| DY Total Computable Incentive Amount: | $ 1,091,269.00 |
| Total Sum of Achievement Values: | 2.00 |
| Total Number of Milestones: | 2.00 |
| Achievement Value Percentage: | 100% |
| Eligible Incentive Funding Amount: | $ 1,091,269.00 |
| Incentive Funding Already Received in DY: | $ 545,634.50 |
| **Incentive Payment Amount:** | $ 545,634.50 |

## Category 3 Summary Page

### At-Risk Populations (required)

| | |
|---|---|
| Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State (DY7-10) | Yes |
| *Achievement Value* | 1.00 |
| Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<8%) measure to the State (DY7-10) | Yes |
| *Achievement Value* | *1.00* |
| Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State (DY8-10) | N/A |
| *Achievement Value* | |
| Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State (DY8-10) | N/A |
| *Achievement Value* | |
| Report results of the Pediatrics Asthma Care measure to the State (DY8-10) | N/A |
| *Achievement Value* | |
| Report results of the Optimal Diabetes Care Composite to the State (DY8-10) | N/A |
| *Achievement Value* | |
| Report results of the Diabetes Composite to the State (DY8-10) | N/A |
| *Achievement Value* | |
| DY Total Computable Incentive Amount: | $ 892,856.00 |
| Total Sum of Achievement Values: | 2.00 |
| Total Number of Milestones: | 2.00 |
| Achievement Value Percentage: | 100% |
| Eligible Incentive Funding Amount: | $ 892,856.00 |
| Incentive Funding Already Received in DY: | $ 446,428.00 |
| **Incentive Payment Amount:** | $ 446,428.00 |

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Natividad Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/230/2012

## 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 (%) | | 0.22 |
| *Achievement Value* | | *1.00* |
| Optional Milestone: | Implement the Sepsis Resuscitation Bundle, as evidenced by: | 0.22 |
| *Achievement Value* | | *1.00* |
| Optional Milestone: | Report at least 6 months of data collection on Sepsis Resuscitation Bundle to SNI | Yes |
| *Achievement Value* | | *1.00* |
| Optional Milestone: | | N/A |
| *Achievement Value* | | |
| Optional Milestone: | | N/A |
| *Achievement Value* | | |
| Optional Milestone: | | N/A |
| *Achievement Value* | | |
| Optional Milestone: | | N/A |
| *Achievement Value* | | |
| Optional Milestone: | | N/A |
| *Achievement Value* | | |
| Optional Milestone: | | N/A |
| *Achievement Value* | | |
| Optional Milestone: | | N/A |
| *Achievement Value* | | |
| DY Total Computable Incentive Amount: | | $ 605,000.00 |
| Total Sum of Achievement Values: | | 3.00 |
| Total Number of Milestones: | | 3.00 |
| Achievement Value Percentage: | | 100% |
| Eligible Incentive Funding Amount: | | $ 605,000.00 |
| Incentive Funding Already Received in DY: | | $ 403,333.33 |
| **Incentive Payment Amount:** | | $ 201,666.67 |

## Category 4 Summary Page

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

| | | |
|---|---|---|
| Compliance with Central Line Insertion Practices (CLIP) (%) | | 0.98 |
| *Achievement Value* | | 1.00 |
| Optional Milestone: | Implement the Central Line Insertion Practices (CLIP), as evidenced by: | Yes |
| *Achievement Value* | | *1.00* |
| Optional Milestone: | Report at least 6 months of data collection on CLIP to SNI for purposes of | Yes |
| *Achievement Value* | | *1.00* |
| Optional Milestone: | Report at least 6 months of data collection on CLABSI to SNI for purposes of | Yes |
| *Achievement Value* | | *1.00* |
| Optional Milestone: | | N/A |
| *Achievement Value* | | |
| 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: | | $ 605,000.00 |
| Total Sum of Achievement Values: | | 4.00 |
| Total Number of Milestones: | | 4.00 |
| Achievement Value Percentage: | | 100% |
| Eligible Incentive Funding Amount: | | $ 605,000.00 |
| Incentive Funding Already Received in DY: | | $ 378,125.00 |
| **Incentive Payment Amount:** | | $ 226,875.00 |

## Category 4 Summary Page

### Hospital-Acquired Pressure Ulcer Prevention

| | | |
|---|---|---|
| Prevalence of Stage II, III, IV or unstagable pressure ulcers (%) | | - |
| *Achievement Value* | | 1.00 |
| Optional Milestone: | Share data, promising practices, and findings with SNI to foster shared learning | Yes |
| *Achievement Value* | | *1.00* |
| Optional Milestone: | | N/A |
| *Achievement Value* | | |
| Optional Milestone: | | N/A |
| *Achievement Value* | | |
| Optional Milestone: | | N/A |
| *Achievement Value* | | |
| Optional Milestone: | | N/A |
| *Achievement Value* | | |
| Optional Milestone: | | N/A |
| *Achievement Value* | | |
| Optional Milestone: | | N/A |
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| 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: | | $ 605,000.00 |
| Total Sum of Achievement Values: | | 2.00 |
| Total Number of Milestones: | | 2.00 |
| Achievement Value Percentage: | | 100% |
| Eligible Incentive Funding Amount: | | $ 605,000.00 |
| Incentive Funding Already Received in DY: | | $ 453,750.00 |
| **Incentive Payment Amount:** | | $ 151,250.00 |

## Category 4 Summary Page

### Venous Thromboembolism (VTE) Prevention and Treatment

| | | |
|---|---|---|
| Optional Milestone: | Put in place measurement/data management systems. | Yes |
| *Achievement Value* | | *1.00* |
| Optional Milestone: | Establish baseline for VTE risk assessment process measures. | Yes |
| *Achievement Value* | | *1.00* |
| Optional Milestone: | Report at least 6 months of data collection on the VTE process measures to SNI | Yes |
| *Achievement Value* | | *1.00* |
| Optional Milestone: | Report the 5 VTE process measures data to the State. | Yes |
| *Achievement Value* | | *1.00* |
| Optional Milestone: | | N/A |
| *Achievement Value* | | |
| Optional Milestone: | | N/A |
| *Achievement Value* | | |
| Optional Milestone: | | N/A |
| *Achievement Value* | | |

| | |
|---|---|
| DY Total Computable Incentive Amount: | $ 605,000.00 |
| Total Sum of Achievement Values: | 4.00 |
| Total Number of Milestones: | 4.00 |
| Achievement Value Percentage: | 100% |
| Eligible Incentive Funding Amount: | $ 605,000.00 |
| Incentive Funding Already Received in DY: | $ 529,375.00 |
| **Incentive Payment Amount:** | $ 75,625.00 |

# DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Natividad Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/230/2012

REPORTING ON THIS PROJECT: *

## Category 1: Increase Training of Primary Care Workforce

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

### *Increase Training of Primary Care Workforce*

DY Total Computable Incentive Amount: * $ 3,330,000.00

Incentive Funding Already Received in DY: * $ 1,665,000.00

**Process Milestone:** Expand Family Medicine Training Program by recruiting two additional first year residents to begin training July 1 2012 thus expanding residency program to 26 total residents

*(insert milestone)*

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

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

Achievement: No

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

Natividad Medical Center submitted a request to the ACGME to increase the residency program by 2 residents as of July 2012. ACGME did not approve the request due to the need for expanded clinic space to accommodate patient volume increase. We continue to work to address the concerns raised by ACGME so that we will be able to add 2 residents to the Family Medicine Training Program by July 2013. This includes resubmission of our request to ACGME by 10/2012 with a clinic plan to build out 20,000 square feet of new clinic space in a Medical Office Building on the hospital campus. The clinic design includes 28 new exam rooms and space for education/conference rooms. Construction for this 6-9 month project is anticipated to begin late fall of 2012. This new design will support group visits as well as integration of Mental Health Services and Social Services into the primary care setting. We plan to add 2 residents to our Family Medicine Program by July 2013 or the latest July 2014.

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

*Achievement Value*: -

**Process Milestone:** Increase the number of primary care trainees by providing training to at least six Touro University Medical Students each academic year.

*(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

Six Touro University Medical Students received training at Natividad Medical Center from July 2011 – June 2012. These Medical Students work side-by-side with Family Medicine Residents and represent a future pool of primary care providers for our underserved community. Of our current 24 Family Medicine Residents, five of them graduated from Touro University Medical School. Additionally, we plan to increase the number of Touro University Students to 8 starting July 2012.

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

*Achievement Value*: 1.00

## Category 1: Increase Training of Primary Care Workforce

| | | |
|---|---|---|
| **Process Milestone:** | Increase the number of primary care trainees by completing new MOU with Stanford University Physician Assistant Program and serve as training site for PA students.<br>*(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 new MOU with the Stanford University Physician Assistant Program was completed. Stanford University Physician Assistant (PA) students are currently doing their clinical training in the Emergency Department and Intensive Care Unit at Natividad Medical Center. One student completed their clinical training at NMC this past year. These PA students represent a future pool of primary care providers for our underserved community. | | |
| 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: Natividad Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/230/2012

REPORTING ON THIS PROJECT: *

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

### *Enhance Interpretation Services and Culturally Competent Care*

DY Total Computable Incentive Amount: * $ 3,330,000.00

Incentive Funding Already Received in DY: * $ 2,997,000.00

**Process Milestone:** Establish baseline data for number of encounters facilitated by qualified interpreters and number of departments utilizing video or audio conference terminals.
*(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

Natividad Medical Center established a baseline for the number of encounters facilitated by qualified interpreters: 160 encounters per month. The baseline includes qualified interpreter encounters via three modalities: in-person, Health Care Interpreter Network (HCIN) video, and Cyracom or HCIN phone.

Natividad Medical Center established a baseline for the number of departments utilizing video or audio conference terminals: 0 departments. NMC joined HCIN in 2010 and initiated the implementation of wireless video terminals throughout the organization. It has been a challenge to install all of the cabling and wireless access points throughout the facility required for the wireless network. There were many “dead” spots that required extensive troubleshooting to resolve. The project included building the mobile units, which consist of a cart, battery pack, wireless receiver, and video unit. Each unit required programming for the network. This project took longer than originally anticipated.

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

*Achievement Value*: 1.00

**Process Milestone:** Implement language access policies and procedures.
*(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

Natividad Medical Center drafted changes to our Language Access policy and procedure based on Straight Talk: Model Hospital Policies & Procedures on Language Access. As of December 2011, the policy and procedure was in the final stages of our committee review process. The policy and procedure was approved by the NMC Medical Executive Committee March 2012, the NMC Board of Trustees April 2012, and was fully implemented by May 2012. The policy and procedure is accessible to all hospital staff via our online policy and procedure database, PolicyManager. This policy and procedure will undergo required regular review and revision with all of our other policies and procedures, at least every 3 years. New hospital staff receives orientation to this policy and procedure during our 8-hour Hospital Orientation class.

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

**Process Milestone:** Expand the number of qualified healthcare interpreters by 100%.
*(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 |

Natividad Medical Center has expanded the number of qualified healthcare interpreters available to provide interpretation services by hiring a second full-time Medical Interpreter as of September 2011 and by providing Bridging the Gap training classes for dual-role staff from key departments/areas throughout the hospital. NMC's Medical Interpreter Coordinator was certified as a trainer for the Bridging the Gap curriculum in June 2011. As of December 2011, NMC held 3 Bridging the Gap training classes which trained 22 dual-role staff for a total of 24 qualified healthcare interpreters. From January – June 2012, NMC was able to hold 2 more Bridging the Gap training classes, training an additional 22 qualified healthcare interpreters. As of June 30, 2012, NMC has 47 qualified healthcare interpreters. NMC partnered with Cross Culture Health Care Program to deliver the Bridging the Gap training in Spanish for the benefit of the Mexican indigenous individuals so that they can be trained as interpreters. Monterey County has a large population whose primary language is Mixteco, Triqui, or Zapoteco. Twenty-seven people attended this training. Two individuals that received this training are now interning at NMC under grant funding.

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

**Process Milestone:** Expand qualified health care interpretation technology to 10% of departments identified in 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 |

Natividad Medical Center identified 17 department locations in our gap analysis that would benefit from using health care interpretation technology for the provision of interpreter services. As of December 2011, 4 of 17 targeted departments were utilizing a video or audio conference terminal which was an increase of 24% over baseline. As of June 30, 2012, 7 of 17 targeted departments were utilizing a video or audio conference terminal which was an increase of 41% over baseline. Ongoing participation in the HCIN network requires ongoing staff training via unit/department meetings and monitoring of the equipment by our Language Access Services staff.

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

**Process Milestone:** Increase number of encounters facilitated by qualified healthcare interpreters to 10% over baseline.
*(insert milestone)*

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

As of December 2011, the number of encounters facilitated by qualified healthcare interpreters at Natividad Medical Center was 311, which was an increase of 94% over baseline. As of June 30, 2012, the number of encounters facilitated by qualified healthcare interpreters at Natividad Medical Center was 1067. NMC was able to accomplish this because of our commitment to training our dual-role staff to become qualified interpreters and the continuing deployment of healthcare interpretation technology as discussed in the milestones 3 and 4 above.

| | |
|---|---|
| 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: Natividad Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/230/2012

REPORTING ON THIS PROJECT: *

## Category 2: Redesign to Improve Patient Experience

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

DY Total Computable Incentive Amount: * $ 3,275,875.00

Incentive Funding Already Received in DY: * $ 818,968.75

Undertake the necessary planning, redesign, translation, training and contract negotiations in order to implement CG-CAHPS in DY8.

**Process Milestone:** Conduct focus groups in one targeted clinical area to establish the baseline patient experience and report findings.

*(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

Natividad Medical Center is participating in the Patient Experience Transformation Initiative (PExT) with the Safety Net Institute and has targeted the Medical/Surgical Unit on the 3rd floor as the clinical area to make improvements related to the patient experience. Fifteen focus groups were conducted throughout January and February 2012 with participation from patients, nursing staff, ancillary staff, physicians, and residents. Two NMC administrators performed unit shadowing. A Design Workshop was held April 17-18, 2012 with multi-disciplinary participation from approximately 15 NMC staff. The design session allowed the NMC PExT Team to analyze the information gathered from the focus groups, shadowing, and patient satisfaction data, identify the top experience gaps and to prioritize organizational strategies aimed at improving patient and family centeredness. Improvement strategies were prioritized as follows: 1) “Quick Wins,” 2) “High Priority – Quick Wins,” and 3) “Long-Term Play.” The Quick Wins were: a) Badge Identification of caregivers, b) equipment purchases of additional bedside commodes for each Med/Surg patient, c) additional seizure pads for the unit, and d) additional Sequential Compression Devices. The Quick Wins were implemented immediately. Four strategies from the “High Priority – Quick Win” category were identified as being critical to improving the patient experience and four performance improvement teams were sanctioned to begin work on the four strategies. They were: 1) Identification of the Caregiver caring for each patient on Med/Surg 3, 2) Improve Patient Education, 3) Standard Room Set-up, and 4) Daily Shift Greeting of the Patient. The work of the four performance improvement teams is continuing into DY8.

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

*Achievement Value*: 1.00

## Category 2: Redesign to Improve Patient Experience

**Process Milestone:** Develop regular organizational display of patient experience data and provide quarterly updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families.

*(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 |

Natividad Medical Center (NMC) believes that an engaged and informed staff helps to improve the patient experience. We have chosen multiple methods of communication based on feedback from our staff. Patient satisfaction survey results, as one of the five organizational keys to success, continue to be displayed on all hospital bulletin boards. In addition, patient satisfaction survey results for the overall quality of care question continues to be included weekly in the organizational "daily huddle" communication provided to all departments. The work that specific units/departments have undertaken to improve the patient experience is also communicated to hospital staff by multiple modalities which include: 1) the Quarterly CEO Forum, 2) our Hospital Performance Improvement Committee meetings, 3) our quarterly HR Newsletter, 4) Med/Surg "Potty Postings" on the back of bathroom doors, and 5) the "Hot Flash" unit newsletter for Med/Surg, ICU and Acute Rehab Units. This has been ongoing for the twelve months of DY7, July2011 – June 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 to Improve Patient Experience

**Process Milestone:** Develop a staff education plan to integrate the patient experience into employee orientation and training.

*(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 |

Natividad Medical Center (NMC) has developed a staff education plan to integrate the patient experience into employee training. In 2008 NMC selected Development Dimensions International (DDI) as its training partner due to its international reputation as a leader of training materials. DDI offers a health care track of courses that range from leadership development to customer service. At this time, NMC trained one master trainer and six facilitators. In DY 6, NMC's DDI master trainer trained and certified six additional facilitators in anticipation of training NMC staff in customer service. The training was three days (2/2/11- 2/4/11). The additional facilitators allowed NMC to readily offer an all day customer service training course to all permanent full-time and part-time staff every Wednesday starting the first quarter FY 2012 through the end of June 2012 (DY 7). The course will be offered at least semi-annually so that new employees can attend. The 8-hour course for the customer service training is DDI's Service Plus® Health Care: Building Patient Loyalty. The course includes the following topics:

- Meet and exceed patients' and other customers' personal and practical needs consistently and reliably.
- Conduct effective, efficient interactions.
- Handle difficult or emotionally charged situations.
- Work as a team to provide service beyond expectations.
- Take personal initiatives that enhance the quality of service offered.

The course allows for team participation throughout the day and culminates with two skill practices where the participants practice the concepts they learned during the training. A total of 654 employees attended the training as of 6/30/2012.

At the end of the training, the participants complete an evaluation of the training. The facilitators review the evaluations after each class to make sure that the training met the needs of the participants. Additionally, as part of the course materials, each participant receives a Service Booster workbook, which includes exercises to reinforce the tactics learned in the Service Plus course. The certified facilitators have conducted Service Booster exercises during monthly Department Manager meetings to demonstrate to the Department Managers how to conduct the exercises in their unit/department. Department Mangers are asked to conduct a Service Booster exercise in their department quarterly.

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

## Category 2: Redesign to Improve Patient Experience

**Process Milestone:** Implement at least one organizational strategy that includes the patient in shared decision making aimed at improving patient and family centeredness.

*(insert milestone)*

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

Natividad Medical Center (NMC) has started but did not fully complete the work associated with implementing one organizational strategy for improving patient and family centeredness. This was because we had to delay scheduling our PExT Design Workshop due to the hospital undergoing a CMS validation survey in December 2011 and re-survey in March 2012. The PExT Design Workshop was held April 17-18, 2012 and enabled Natividad Medical Center to prioritize organizational strategies aimed at improving patient and family centeredness. Two "Quick Win" strategies, which are components of two of the "High Priority – Quick Win" category projects were identified and implemented by June 30, 2012, but the larger scope projects, were not completed. Badge identification of caregivers is part of the Identification of the Caregiver strategy. It was prioritized as important in building trust between the patient and caregivers. "Badge Buddies" noting "RN" or "Nursing Assistant" were distributed to all Med/Surg 3 caregivers by 5/31/2012. The purchase of some key equipment is part of the Standard Room Set-up strategy. It was prioritized as important for improving our patient/family experience because the existing equipment was either old and tattered or resulted in wasted staff time because of equipment shortage. Additional bedside commodes were purchased so that there is one for each patient room. The new commodes were put in to use as of 6/30/2012. Additional seizure pads were purchased and implemented by 5/31/2012 on the Med/Surg 3 Unit. Additional Sequential Compression Devices were ordered so that each patient bed will have one.

Four strategies from the "High Priority – Quick Win" category were identified as being critical to improving the patient experience and four performance improvement teams were sanctioned to begin work on the four strategies. They were: 1) Identification of the Caregiver caring for each patient on Med/Surg 3, 2) Improve Patient Education, 3) Standard Room Set-up, and 4) Daily Shift Greeting of the Patient. The work of the four performance improvement teams is continuing into DY8, with targeted completion by 12/31/2012 for all four teams.

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

# DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Natividad Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/230/2012

REPORTING ON THIS PROJECT: *

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

Below is the data reported for the DPH system.

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

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

### *Apply Process Improvement Methodology to Improve Quality/Efficiency*

| | | |
|---|---|---|
| DY Total Computable Incentive Amount: | * | $ 3,275,875.00 |
| Incentive Funding Already Received in DY: | * | $ 2,183,916.67 |
| **Process Milestone:** Train process improvement advisors/champions. *(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 Quality Nurses and the CMO attended the IHI National Forum in December 2011 where they participated in educational sessions focused on leading process improvement initiatives. The Quality Director and another Quality Nurse attended part of the Forum. The attended sessions included:
• Reducing Clinical Variation Through Physician Engagement
• Measures Matter: Determining Metrics of Care that Matter Most to Patients
• "Bolt-on" to "Built-in": Quality as Cultural DNA
• Practical Tools to Spread Improvement and Achieve Results at Scale

One Quality Nurse attended a 4-day LEAN Training Course taught by instructors from the Institute for Performance Excellence sponsored by the Beacon Collaborative in February/March 2012.
The course curriculum consisted of:
• Module 1 – Introduction to Lean
• Module 2 – Plan Phase
• Module 3 – SIPOC Phase
• Module 4 – Charter
• Module 5 – Introduction to Teams
• Module 6 – Voice of the Customer
• Module 7 – Process map
• Module 8 – Cycle Time/Value Analysis
• Module 9 – Flow Factor
• Module 10 – Data Collection
• Module 11 – Cause and Effect
• Module 12 – Identify Improvement Opportunities
• Module 13 – Create a Lean Pathway
• Module 14 – Implement Lean Improvements
• Module 15 – Kaizen Events and Implementing Controls

The Quality Director and three Quality Nurses are serving as Quality Advisors for a number of performance improvement projects throughout our organization.

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

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

**Process Milestone:** Convene training events conducted by designated process improvement trainers.
*(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 |

NMC has adopted the Model for Improvement as our framework for performance improvement. The curriculum for process improvement training is from the Institute for Healthcare Improvement (IHI). The curriculum for our performance improvement training includes 4 2-hour courses.
• An Introduction to the Model for Improvement
• The Right Treatment for the Right Patient Every Time –Applying Reliability Science to Health Care
• Effective Teamwork as a Care Strategy –SBAR and Other Tools
• Just Culture
Three of the courses listed above are from IHI's on-demand video course library and one is a based on the work of David Marx. Three training events were conducted by designated process improvement trainers July 2011 – December 2011 and 2 were conducted January –June 2012. At least 170 administrators, managers, supervisors and charge nurses have completed the training. Training will be conducted quarterly for new staff joining our organization. We are evaluating the effectiveness of this training by counting the number of Hospitalwide Performance Improvement Teams that are utilizing the Model for Improvement each year. During DY7, we had 8 teams utilizing the Model for Improvement as a performance improvement framework. An additional method of evaluating the effectiveness of our performance improvement training is the review of department performance improvement projects. Twice a year, each Department Manager must present a department-specific project, in which they utilized the Model for Improvement, at the hospital's Performance Improvement Committee meeting. We are in the process of developing a team self-evaluation to be used at the end of a performance improvement project.

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

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

**Process Milestone:** Target 1 specific workflows, processes or clinical areas to improve utilizing the Model for Improvement framework.

*(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 |

A performance improvement team was sanctioned in 2011 to reduce ventilator-associated-pneumonia (VAP) by focusing on compliance with bundle practices – especially maintaining the head-of-the-bed at >30°. Our baseline performance for FY 2009 was: 5 infections, our 12-month rolling rate was 10.5 and we did not collect data on compliance with the bundle practices or the number of days between infections. In 2010, we started implementing the bundle practices. In FY 2010, we had 4 infections, the rolling rate had decreased to 4.4, we went 175 days between infections and we were 65% compliant with keeping the head-of-the-bed (HOB) ≥30°. Compliance with the other bundle practices was over 90%. We were not content with our performance and we formed a team which utilized the Model for Improvement framework. Our team met regularly from February – July 2011. We conducted multiple tests-of-change as we implemented several interventions which included: incorporation of HOB check into the Respiratory Therapists 2-hour ventilator rounds, implementation of a sign over the patient's bed as a reminder to the care team to keep the HOB ≥30°, incorporation of the VAP bundle practices into multi-disciplinary rounds led by the ICU Intensivist and into the physician's daily documentation tool, and implementation of an auditing process every 2 hours by the Unit Clerk. The Team achieved success in maintaining the head-of-the-bed at >30° 100% of the time. For FY 2011, we had 1 infection, a rolling rate of 1.3, and went 285 days between infections. For FY 2012, we had 0 infections, a rolling rate of 0, and went over 430 days without an infection.

| | | |
|---|---|---|
| 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: Natividad Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/230/2012

**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
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***Patient/Care Giver Experience (required)***

| | | |
|---|---|---|
| DY Total Computable Incentive Amount: | * | $ 892,856.00 |
| Incentive Funding Already Received in DY: | * | $ 892,856.00 |

**Undertake the necessary planning, redesign, translation, training and contract negotiations in order to implement CG-CAHPS in DY8 *(DY7 only)***

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

Work has been completed to fully implement the CG-CAHPS survey at Natividad Medical Center's Natividad Medical Group (NMG) clinic and the Monterey County Health Department's Laurel Family Medicine (LFM) Clinic. The contract with PRC was established, test files were sent to PRC in November, 2011, and patient surveys are being conducted as of March 2012. Survey results are being shared with NMG and LFM providers.

| | |
|---|---|
| Achievement | Yes |
| *Achievement Value* | 1.00 |

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Natividad Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/230/2012

**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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## *Care Coordination (required)*

| | | |
|---|---|---|
| DY Total Computable Incentive Amount: | * | $ 1,091,269.00 |
| Incentive Funding Already Received in DY: | * | $ 545,634.50 |

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

| | | |
|---|---|---|
| Data Collection Source | * | Electronic medical record (EMR) |
| Numerator | * | 2.0 |
| Denominator | * | 549.0 |
| 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):

Regular meetings with key stakeholders at Natividad Medical Center's Natividad Medical Group clinic and Laurel Family Medicine clinic were held throughout DY7 to develop processes and procedures to collect numerator and denominator data related to Diabetes. Data sharing between the two entities was accomplished for July 2011 – June 2012. Natividad Medical Center (NMC) opened an ambulatory Diabetic Education Center January 2012 and received accreditation by the American Academy of Diabetic Educators in June 2012. Patients are referred to the Diabetic Education Center from NMC, Natividad Medical Group (NMG), Laurel Family Medicine clinic, other Health Department Clinics, and community clinics.

#6 Diabetes: Short-Tem Complications
• Baseline (July – December 2011) 1/563 = 0.2%
• 12 Months (July – June 2012) 2/549 = 0.4%

NOTE: We determined the following error in our denominator for Diabetes patients ages 18 – 75 that was reported in the March 2012 report for July 2011 – December 2011 data.
• For measures # 6 and #7, the original reported denominator of 563 was incorrect because it included all patients over age 18 for one of our clinic locations. After filtering raw data to include only patients ages 18 – 75, the correct denominator is 549.

| | |
|---|---|
| Achievement | Yes |
| *Achievement Value* | 1.00 |

## Category 3: Care Coordination *(required)*

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

| | | |
|---|---|---|
| Data Collection Source | * | Electronic medical record (EMR) |
| Numerator | * | 20.0 |
| Denominator | * | 549.0 |
| Rate | | 3.6 |

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

Regular meetings with key stakeholders at Natividad Medical Center's Natividad Medical Group clinic and Laurel Family Medicine clinic were held throughout DY7 to develop processes and procedures to collect numerator and denominator data related to Diabetes. Data sharing between the two entities was accomplished for July 2011 – June 2012. Natividad Medical Center (NMC) opened an ambulatory Diabetic Education Center January 2012 and received accreditation by the American Academy of Diabetic Educators in June 2012. Patients are referred to the Diabetic Education Center from NMC, Natividad Medical Group (NMG), Laurel Family Medicine clinic, other Health Department Clinics, and community clinics.

#7 Diabetes: Uncontrolled
• Baseline (July – December 2011) 10/563 = 1.8%
• 12 Months (July – June 2012) 20/549 = 3.6%

NOTE: We determined the following error in our denominator for Diabetes patients ages 18 – 75 that was reported in the March 2012 report for July 2011 – December 2011 data.
• For measures # 6 and #7, the original reported denominator of 563 was incorrect because it included all patients over age 18 for one of our clinic locations. After filtering raw data to include only patients ages 18 – 75, the correct denominator is 549.

| | |
|---|---|
| Achievement | Yes |
| *Achievement Value* | 1.00 |

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Natividad Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/230/2012

**Category 3: Preventive Health *(required)***

Below is the data reported for the DPH system.

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

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

## *Preventive Health (required)*

| | | |
|---|---|---|
| DY Total Computable Incentive Amount: | * | $ 1,091,269.00 |
| Incentive Funding Already Received in DY: | * | $ 545,634.50 |

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

| | | |
|---|---|---|
| Data Collection Source | * | Electronic medical record (EMR) |
| Numerator | * | 400.0 |
| Denominator | * | 604.0 |
| Rate | | 66.2 |

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

Regular meetings with key stakeholders at Natividad Medical Center's Natividad Medical Group clinic and Laurel Family Medicine clinic were held throughout DY7 to develop processes and procedures to collect numerator and denominator data related to Mammography and Influenza Immunization. Data sharing between the two entities was accomplished for July 2011 – June 2012. Natividad Medical Group (NMG) operates with a hybrid medical record; some data such as lab results are in the electronic medical record but most other documentation is still paper. Prior to implementing an ambulatory management system, NMG is in the process of implementing an interim solution for capturing the data elements related to mammography screening and influenza immunization for each patient visit. This data will be entered into Meditech's Advanced EMR. Laurel Family Medicine (LFM) uses the EPIC system for their electronic medical record. LFM has made changes to their patient's Problem Summary List in EPIC to improve this important data collection and remind providers to address these issues with their patients. We are planning to implement the i2i Health Management Software to assist us in preventive health management for both entities. Contract negotiations for the i2i solution are underway.

#10 Mammography Screening
• Baseline (July – December 2011) 290/604 = 48%
• 12 Months (July – June 2012) 400/604 = 66%

| | |
|---|---|
| Achievement | Yes |
| *Achievement Value* | 1.00 |

## Category 3: Preventive Health *(required)*

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

| | | |
|---|---|---|
| Data Collection Source | * | Electronic medical record (EMR) |
| Numerator | * | 372.0 |
| Denominator | * | 1,160.0 |
| Rate | | 32.1 |

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):

Regular meetings with key stakeholders at Natividad Medical Center's Natividad Medical Group clinic and Laurel Family Medicine clinic were held throughout DY7 to develop processes and procedures to collect numerator and denominator data related to Mammography and Influenza Immunization. Data sharing between the two entities was accomplished for July 2011 – June 2012. Natividad Medical Group (NMG) operates with a hybrid medical record; some data such as lab results are in the electronic medical record but most other documentation is still paper. Prior to implementing an ambulatory management system, NMG is in the process of implementing an interim solution for capturing the data elements related to mammography screening and influenza immunization for each patient visit. This data will be entered into Meditech's Advanced EMR. Laurel Family Medicine (LFM) uses the EPIC system for their electronic medical record. LFM has made changes to their patient's Problem Summary List in EPIC to improve this important data collection and remind providers to address these issues with their patients. We are planning to implement the i2i Health Management Software to assist us in preventive health management for both entities. Contract negotiations for the i2i solution are underway.

#11 Influenza Immunization
• Baseline (July – December 2011) 273/1160 = 23.5%
• 12 Months (July – June 2012) 372/1160 = 32%

| | |
|---|---|
| Achievement | Yes |
| *Achievement Value* | 1.00 |

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Natividad Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/230/2012

## 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: | * | $ 892,856.00 |
| Incentive Funding Already Received in DY: | * | $ 446,428.00 |

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

| | | |
|---|---|---|
| Data Collection Source | * | Electronic medical record (EMR) |
| Numerator | * | 224.0 |
| Denominator | * | 549.0 |
| Rate | | 40.8 |

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

Regular meetings with key stakeholders at Natividad Medical Center's Natividad Medical Group clinic and Laurel Family Medicine clinic were held throughout DY7 to develop processes and procedures to collect numerator and denominator data related to Diabetes. . Data sharing between the two entities was accomplished for July 2011 – June 2012. Natividad Medical Group (NMG) operates with a hybrid medical record. Some lab results are in the electronic medical record but most other documentation is still paper. Prior to implementing an ambulatory management system, NMG is in the process of implementing an interim solution for capturing the data elements related to diabetes for each patient visit. This data will be entered into Meditech's Advanced EMR. Laurel Family Medicine uses the EPIC system for their electronic medical record. We are planning to implement the i2i Health Management Software to assist us in chronic disease management for both entities. Contract negotiations for the i2i solution are underway.

#15 LDL Control (<100 mg/dl)
• Baseline(July – December 2011) 110/551 = 20%
• 12 Months (July – June 2012) 224/ 549 = 41%

NOTE: We determined the following error in our denominator for Diabetes patients ages 18 – 75 that was reported in the March 2012 report for July 2011 – December 2011 data.
• For Measures #15 and #16, the original reported denominator of 551 was incorrect because it included two duplicate patients from one of our clinic locations. After filtering the list of duplicates, the correct denominator is 549.

| | |
|---|---|
| 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 | * | 197.0 |
| Denominator | * | 549.0 |
| Rate | | 35.9 |

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):

Regular meetings with key stakeholders at Natividad Medical Center's Natividad Medical Group clinic and Laurel Family Medicine clinic were held throughout DY7 to develop processes and procedures to collect numerator and denominator data related to Diabetes. . Data sharing between the two entities was accomplished for July 2011 – June 2012. Natividad Medical Group (NMG) operates with a hybrid medical record. Some lab results are in the electronic medical record but most other documentation is still paper. Prior to implementing an ambulatory management system, NMG is in the process of implementing an interim solution for capturing the data elements related to diabetes for each patient visit. This data will be entered into Meditech's Advanced EMR. Laurel Family Medicine uses the EPIC system for their electronic medical record. We are planning to implement the i2i Health Management Software to assist us in chronic disease management for both entities. Contract negotiations for the i2i solution are underway.

#16 Hemoglobin A1C Control (<8mg/dl)
• Baseline(July – December 2011) 56/551 = 15.6%
• 12 Months (July – June 2012) 197/549 = 36%

NOTE: We determined the following error in our denominator for Diabetes patients ages 18 – 75 that was reported in the March 2012 report for July 2011 – December 2011 data.
• For Measures #15 and #16, the original reported denominator of 551 was incorrect because it included two duplicate patients from one of our clinic locations. After filtering the list of duplicates, the correct denominator is 549.

| | |
|---|---|
| Achievement | Yes |
| *Achievement Value* | 1.00 |

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Natividad Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/230/2012

**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: | * | $ 605,000.00 |
| Incentive Funding Already Received in DY: | * | $ 403,333.33 |
| **Compliance with Sepsis Resuscitation bundle (%)** | | |
| Numerator | * | 11 |
| Denominator | * | 51 |
| % Compliance | | 0.22 |

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):

Sepsis Morality and Resuscitation Bundle results for 12 months (January – December 2011) are being reported to the state in this report. Baseline Data is: TOTAL for January – December 2011: Mortality = 16/51 or 31% Bundle Compliance = 11/51 or 22%

Our sepsis data for January – June 2012 was abstracted and analyzed using the new methodology for abstraction/case finding. Results are as follows:

January – June 2012: Morality = 9/29 or 31% Bundle Compliance = 15/29 or 52%

We have achieved improvement in bundle compliance of 24% over our baseline performance using the new methodology.

| | | |
|---|---|---|
| DY Target (from the DPH system plan, if appropriate) | * | 1.00 |
| % Achievement of Target | | 4.64 |
| *Achievement Value* | | 1.00 |

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

**Optional Milestone:**

Implement the Sepsis Resuscitation Bundle, as evidenced by:

- Implementation of a measurement/data management system
- Establishment of baseline data for Sepsis Bundle Process Measures
- Participate in a collaborative to learn and share best practices related to improving severe sepsis

| | | |
|---|---|---|
| Numerator (if N/A, use "yes/r | * | 11.00 |
| Denominator (if absolute number, enter "1") | * | 51.00 |
| Achievement | | 0.22 |
| If "yes/no" as to whether the milestone has been achieved, 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 |

1. Natividad Medical Center developed a system for measurement and data management for sepsis cases; analysis of bundle compliance and calculation of our sepsis mortality rate. We designed and implemented the use of an excel spreadsheet to manage the sepsis data. We followed the methodology of data collection described in the CHA/SNI document initially provided, selecting cases for bundle compliance and calculating the sepsis mortality rate. The Information Technology department at NMC provided a list of patients that were over 18 years of age and met the criteria for selection by using the methodology described to identify cases from Table 1, 2, and 3. The mortalities were identified and a monthly rate was established exactly as described in the technical specifications.

2. Natividad Medical Center established our baseline performance data of compliance with the Sepsis Bundle Processes January – June 2011. This data was submitted to SNI by December 31, 2011. We abstracted July – December 2011 data and submitted it to SNI by March 15, 2012. All cases on the list were abstracted, using a tool obtained on the SNI portal. Specifically, the cases were reviewed for bundle compliance using the definitions provided. The four bundle practices that were abstracted were: a) serum lactate measured b) blood culture obtained prior to antibiotic administration c) Broad spectrum antibiotics administered within 3 hours for ED patients and within 1 hour for non-ED patients d) In the event of hypotension and/or lactate > 4 mmol/L, deliver a bolus of crystalloid fluid equivalent to 20 ml/kg and apply vasopressors for hypotension not responding to initial fluid resuscitation to maintain MAP>65mm/Hg.

It became apparent that not all cases on the list were sepsis cases and it was an arduous task to attempt to find a time of presentation on a case that was not a severe sepsis or septic shock case. Nurse abstractors were not always clear at what point bundle practices should be implemented on cases that were not clearly septic. This was very time intensive. It was decided that the final data analysis to be reported would be those cases that we felt needed the bundle implemented. Cases with presentation of hypotension and/or a lactate greater than 4 were selected as our reporting cohort. Bundle practices were reported as met if all bundle elements were met. There was considerable discomfort with our data due to the overwhelming amount of data to abstract the infinite variety of sepsis presentations and the lack of precise and clear definitions to use for abstraction. In addition, there was concern as to the meaningfulness of the data going forward with changes coming from the state.

The new methodology, provided by the State through CHA/SNI in August, for identifying cases has simplified the process of data abstraction by using only two ICD-9 codes related to severe sepsis and septic shock. The cases were much easier to abstract, as they clearly were septic cases and the time of presentation was less time consuming and easier to identify. All cases were included in our data (after exclusion criteria). In addition, the number of cases needing abstraction became more reasonable for our small hospital to manage.

NMC leadership decided to rework our baseline data using only the cases with the two ICD-9 codes. The rationale was that utilizing this new methodology would provide a meaningful baseline for comparison with our current and future performance. The case count on our original baseline data was 137 and dropped to 51 using the new methodology for the calendar year 2011. For our baseline data the overall mortality rate was 20% per original methodology and was 31.3% using the new methodology. Bundle compliance was found to be 27% using the original methodology for our baseline data but using the new methodology it was 22%. Abstraction was done for January-June 2012 using the new methodology. There were 29 cases identified (after exclusion criteria). The overall mortality rate was 31%, and bundle compliance was 52%. The abstractors feel much more confident in the new baseline data because the cases were appropriate for sepsis review unlike the majority of the cases identified using the first methodology. We were encouraged to see that our compliance with bundle practices has improved due to participation in the collaborative, development of a screening tool and order sets for sepsis that has occurred this last year.

3. Natividad Medical Center is an active participant in the SNI Sepsis Collaborative. Team representatives have attended all required meetings July 2011 – June 2012. NMC participated in the IHI Sepsis Expedition in addition to the SNI Sepsis Collaborative, which enhanced our learning associated with sepsis management. In November 2011, we had three teams representing our ICU and Emergency Department participate in Sepsis Case Simulation where a simulation bus, sponsored by the Beacon Collaborative/California Hospital Association, parked on our campus. Two of our Sepsis Team members attended one Beacon collaborative meeting on Sepsis/CLABSI.

Our Sepsis Performance Improvement Team, led by two physician champions – one in the Emergency Department and one in the ICU, is working on implementing a Sepsis Screening Tool in the Emergency Department. The team has performed several tests-of-change/Plan Do Study Act cycles. Learning from the testing cycles included the need to reformat the form with color-coding for each section to make it easier to determine who should complete each section of the form and changing a single check-box to several Yes/No boxes. The form is still in the testing phase, with full implementation and spread planned for the fall. Once the screening tool is fully implemented in the Emergency Department, we will implement a sepsis screening tool for our inpatient units. Additionally, we have designed and implemented new Sepsis Orders in the Emergency Department and ICU that incorporate all sepsis management bundle practices.

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

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

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

*(insert milestone)*

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

Natividad Medical Center reported 6 months of data on Sepsis Mortality and compliance with the Sepsis Resuscitation Bundle to SNI as of December 31, 2011. SNI will use the data to establish the baseline and setting benchmarks.

Sepsis Baseline Data – Original Method of Abstraction/Case Finding
January – June 2011: Mortality = 13/73 or 18% Bundle Compliance = 7/30 or 23%
July – December 2011: Mortality = 15/64 or 23% Bundle Compliance = 9/29 or 31%
TOTAL for January – December 2011: Mortality = 28/ 137 or 20% Bundle Compliance = 16/59 or 27%

Sepsis Baseline Data – New Method of Abstraction/Case Finding
January – June 2011: Mortality= 7/25 or 28% Bundle Compliance = 9/25 or 36%
July – December 2011: Mortality = 9/26 or 35% Bundle Compliance = 2/26 or 8%
TOTAL for January – December 2011: Mortality = 16/51 or 31% Bundle Compliance = 11/51 or 22%

| | |
|---|---|
| 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: Natividad Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/230/2012

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

Below is the data reported for the DPH system.

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

* The yellow boxes indicate where the DPH system should input data
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### *Central Line Associated Blood Stream Infection*

| | | |
|---|---|---|
| DY Total Computable Incentive Amount: | * | $ 605,000.00 |
| Incentive Funding Already Received in DY: | * | $ 378,125.00 |
| **Compliance with Central Line Insertion Practices (CLIP) (%)** | | |
| Numerator | * | 188.00 |
| Denominator | * | 192.00 |
| % Compliance | | 0.98 |

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):

CLIP results for 12 months (June 2011 – May 2012) are being reported to the state in this report.

CLIP
June – November 2011: 112/117 = 96% (ICU and NICU)
December – May 2012: 114/116 = 98% (ICU and NICU)
12 Months
June 2011 – May 2012: 154/158 = 97% for ICU
34/34 = 100% for NICU
TOTAL: 188/192 = 98% (ICU and NICU)

| | | |
|---|---|---|
| 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), as evidenced by:

- Implementation of a Central Line Cart for supplies
- Implementation of Multi-disciplinary Rounds in the ICU
- Performance Improvement Team meeting regularly
- Participation in a collaborative
- Implementation of the SHEA Compendium practices

| | |
|---|---|
| Numerator (if N/A, use "yes/ | * |
| Denominator (if absolute nur | * |
| 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 |

Natividad Medical Center first started working on Central Line Insertion Practices (CLIP) and implementing a cart/kit in 2008 when the California Department of Public Health (CDPH) required reporting of CLIP through CDC's NHSN database. Our first test-of-change for implementing the CLIP Form for collecting data related to the bundle practices resulted in redesigning the form several times to make it more user-friendly for staff. The CLIP form has been added to each Central Line Insertion kit, serving as a checklist/reminder regarding proper insertion practices for clinical staff. As of May 2011, the CLIP elements have been incorporated into Meditech for nursing documentation when a central line is inserted. In 2010, analysis of our Central Line Infection data revealed a large number of femoral lines being left in patients for a number of days and the need for PICC Line Nurses. We trained the nurses and scheduled them so that PICC lines are inserted to replace femoral lines inserted in the Emergency Department within 24 hours.

1. Natividad Medical Center has implemented the use of Central Line Kit /Cart that contains all necessary components for aseptic catheter insertion and is easily accessible where central venous catheters are inserted. Several tests-of-change/PDSA cycles were conducted related to implementing a Central Line Kit/Cart. The ICU and NICU teams identified the need to assemble and organize all necessary supplies and components for aseptic catheter insertion. The NICU implemented a cart. Due to space constraints in the ICU and the Emergency Department, stakeholders met to design a kit instead of a cart with all necessary supplies including chlorhexadine gluconate, maximal barrier drape, mask, cap, sterile gown and sterile gloves. A subsequent test-of-change revealed that we needed to add the biopatch to the kit to insure that it would be used. The most recent test-of-change identified the need to add IV access ports, a sterile cover for the ultrasound probe, and a sutureless securement dressing. All items in the newest kit are organized according to how the clinician uses the items when inserting a central line.
2. Natividad Medical Center has implemented Multi-disciplinary Rounds in the ICU. Daily rounds are led by the ICU attending physician and all disciplines participate. During Daily Rounds, the team performs an assessment for central line necessity.
3. Natividad Medical Center has sanctioned a Performance Improvement Team to work on prevention of central line-associated blood stream infections. The multi-disciplinary team has met throughout DY7.
4. Natividad Medical Center is an active participant in the SNI CLABSI Collaborative. Team representatives have attended all required meetings July 2011 –June 2012.
5. Natividad Medical Center has implemented the use of port protectors impregnated with alcohol to reduce risk of contamination when ports are accessed. In order to improve compliance with using the port protectors, we recently implemented using the port protectors on a strip that can hang on an IV pole versus individual ones in a box. Plans are underway to standardize dressings for central lines by implementing a dressing change kit.

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

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

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

*(insert milestone)*

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

Natividad Medical Center reported 6 months of data on CLIP (June – November 2011) to SNI as of December 31, 2011. SNI will use the data to establish the baseline and setting benchmarks. We are unable to use data prior to June 2011 for our baseline for CLIP because we implemented nursing documentation in Meditech as of May 2011. Data collection prior to this is unreliable.

CLIP
June – November 2011: 112/117 = 96% (ICU and NICU)
December – May 2012: 114/116 = 98% (ICU and NICU)
12 Months
June 2011 – May 2012: 154/158 = 97% for ICU
34/34 = 100% for NICU
TOTAL: 188/192 = 98% (ICU and NICU)

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

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

*(insert milestone)*

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

Natividad Medical Center reported 6 months of data on CLABSI (June – November 2011) to SNI as of December 31, 2011. SNI will use the data to establish the baseline and setting benchmarks.
CLABSI
June – November 2011: 0 infections / 443 ICU central line days (0.00 CLABSI per 1000 central line days)
0 infections / 77 NICU central line days (0.00 CLABSI per 1000 central line days)
December – May 2012: 1 infection/725 ICU central line days (1.4 CLABSI per 1000 central line days)
0 infections / 50 NICU central line days (0.00 CLABSI per 1000 central line days)
TOTAL 12 Months Baseline:
June 2011 – May 2012: 1 infection/1168 ICU central line days (0.86 CLABSI per 1000 central line days)
0 infections/127 NICU central line days (0.00 CLABSI per 1000 central line days)

| | |
|---|---|
| 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: Natividad Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/230/2012

## Category 4: Hospital-Acquired Pressure Ulcer Prevention

REPORTING ON THIS PROJECT: *

Below is the data reported for the DPH system.

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

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

### *Hospital-Acquired Pressure Ulcer Prevention*

| | | |
|---|---|---|
| DY Total Computable Incentive Amount: | * | $ 605,000.00 |
| Incentive Funding Already Received in DY: | * | $ 453,750.00 |
| **Prevalence of Stage II, III, IV or unstagable pressure ulcers (%)** | | |
| Numerator | * | 0.00 |
| Denominator | * | 111.00 |
| Prevalence (%) | | - |

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

Natividad Medical Center performs pressure ulcer prevalence screening on a quarterly basis using the Cal-NOC criteria and methodology.

Hospital-acquired pressure ulcer results for 12 months (July 2011 – June 2012) are being reported to the state in this report.
July – December 2011= 0/67 or 0%
January – June 2012 = 0/44 or 0%
TOTAL = 0/111 or 0%

| | | |
|---|---|---|
| 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 practices, and findings with SNI to foster shared learning and benchmarking across the California public hospitals.

*(insert milestone)*

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

Natividad Medical Center reported our current data, promising practices and findings to SNI as of December 31, 2011. SNI will use the data to foster shared learning and benchmarking. Our work on pressure ulcer prevention is led by our Wound Care Nurse and our Pressure Ulcer Prevention Performance Improvement Team. Our work on pressure ulcer prevention during DY7 is summarized below.

NMC partnered with Medline to host a "Wound Care Boot Camp" in January 2012. The 8-hour course reviewed the following:
• Overview of a comprehensive wound management program including Anatomy and Physiology of the skin, normal wound healing, factors affecting wound closure,
• Development of a comprehensive prevention program, assessment & documentation, managing bioburden in wounds and topical dressing selection.

Our Pressure Ulcer Prevention Team developed and implemented a Bed Choice Flowsheet/Decision Process "Support Surface" Algorithm to make sure nursing staff use the right bed for each patient in order to minimize skin breakdown. The team evaluated and implemented new products for wound care and modified the pre-printed order form accordingly. The team designed and implemented a new Care Plan for Pressure Ulcers in the Meditech computer system. The team developed an education tool, "Guide to Prevent Pressure Ulcers" for patients and family. The Pressure Ulcer Prevention Team provided oversight regarding the purchase and implementation of 62 new mattresses which are designed to reduce development of pressure ulcers. The team designed and implemented a process for nursing staff to order a consult by a Pressure Ulcer Resource Nurse. A Core Team of 5 nurses completed their training and competencies in order to provide consultations to staff as requested, rounding on high risk patients, assisting with product selections, helping with the development of treatment plans and assisting with dressing changes. This team of Pressure Ulcer Resource Nurses provides coverage 5 days a week, Monday - Friday.

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

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Natividad Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/230/2012

## Category 4: Venous Thromboembolism (VTE) Prevention and Treatment

REPORTING ON THIS PROJECT: *

Below is the data reported for the DPH system.

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

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

### *Venous Thromboembolism (VTE) Prevention and Treatment*

DY Total Computable Incentive Amount: * $ 605,000.00

Incentive Funding Already Received in DY: * $ 529,375.00

**Optional Milestone:** Put in place measurement/data management systems.
*(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

Natividad Medical Center established a measurement/data management system for Venous Thromboembolus Prevention and Treatment. Data is abstracted, compiled and analyzed via the Truven Health, formerly Thomson Reuters Care Discovery Quality System. We implemented this process, utilizing our Quality Nurses for abstraction and analysis, beginning with April 2011 discharges and have continued consistently since.

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

*Achievement Value*: 1.00

**Optional Milestone:** Establish baseline for VTE risk assessment process measures.
*(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

Natividad Medical Center established our baseline performance data for Venous Thromboembolus Prevention and Treatment (5 VTE process measures) April – September 2011. The data for our baseline performance is outlined in the narrative for milestone #3 below.

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

*Achievement Value*: 1.00

## Category 4: Venous Thromboembolism (VTE) Prevention and Treatment

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

Natividad Medical Center reported 6 months of data on the VTE process measures to SNI as of December 31, 2011. SNI will use the data to establish the baseline and setting benchmarks. See baseline data (April - September 2011):
1) VTE Prophylaxis (%): 134/164 = 82%
2) ICU VTE Prophylaxis (%): 40/42 = 95%
3) VTE Patients with Anticoagulation Overlap Therapy (%): 4/4 = 100%
4) VTE Patients receiving unfractionated heparin with dosages/platelet count monitoring (%): 1/1 = 100%
5) VTE Discharge Instructions (%): 0/2 = 0%
6) Incidence of Potentially Preventable Venous Thromboembolism (%): 0/1 = 0%

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

*Achievement Value*: 1.00

**Optional Milestone:** Report the 5 VTE process measures data to the State.
*(insert milestone)*

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

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

Achievement: Yes

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

The 5 VTE process measures data for 12 months (April 2011 – March 2012) are being reported to the state in this report.
1) VTE Prophylaxis (%): 152/191 = 80%
2) ICU VTE Prophylaxis (%): 36/37 = 97%
3) VTE Patients with Anticoagulation Overlap Therapy (%): 10/10 = 100%
4) VTE Patients receiving unfractionated heparin with dosages/platelet count monitoring (%): 0/4 = 0%
5) VTE Discharge Instructions (%): 0/8 = 0%
6) Incidence of Potentially Preventable Venous Thromboembolism (%): 1/1 = 100%
Abstraction and analysis of April – June 2012 data is underway now.

Analysis of our baseline data revealed a significant opportunity to improve our performance on the provision of patient education related to warfarin. Our performance improvement team has developed a new process for Nursing to utilize an online patient education database, EBSCO-PERC. The team is currently testing the process via a small test-of-change (plan-do-study-act) cycles and will go live with it (implementation and spread) in late fall. Other work by the performance improvement team to improve our performance on the process measures include: development a new VTE Risk Assessment and Order form to be incorporated into every patient's admission orders, review and revision of our Anticoagulation Order Form for Overlap Therapy, and development a new Discharge Order Form to capture acceptable exclusions for patients being discharged on anticoagulants. New order screens have been developed into our Meditech Computer system to capture all of this data. The Medical Executive Committee as has sanctioned the development of a new Pharmacy-driven protocol for managing heparin, which will incorporate documentation of platelet monitoring. We plan to go live with this new protocol in late fall. The work of this performance improvement team is also responsible for our work on the Meaningful Use Clinical Quality Measures.

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

*Achievement Value*: 1.00