DSRIP Semi-Annual Reporting Form

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

* **DPH SYSTEM:**	Riverside County Regional Medical Center
* **REPORTING YEAR:**	DY 7
* **DATE OF SUBMISSION:**	9/28/2012

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	$ 1,507,218.75
Increase Training of Primary Care Workforce	$ -
Implement and Utilize Disease Management Registry Functionality	$ -
Enhance Interpretation Services and Culturally Competent Care	
Collect Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities	
Enhance Urgent Medical Advice	
Introduce Telemedicine	
Enhance Coding and Documentation for Quality Data	
Develop Risk Stratification Capabilities/Functionalities	
Expand Specialty Care Capacity	$ 3,014,437.50
Enhance Performance Improvement and Reporting Capacity	
TOTAL CATEGORY 1 INCENTIVE PAYMENT:	$ 4,521,656.25
Category 2 Projects	
Expand Medical Homes	$ -
Expand Chronic Care Management Models	$ -
Redesign Primary Care	$ 4,823,100.00
Redesign to Improve Patient Experience	$ 3,215,400.00
Redesign for Cost Containment	
Integrate Physical and Behavioral Health Care	
Increase Specialty Care Access/Redesign Referral Process	$ 4,823,100.00
Establish/Expand a Patient Care Navigation Program	
Apply Process Improvement Methodology to Improve Quality/Efficiency	
Improve Patient Flow in the Emergency Department/Rapid Medical Evaluation	
Use Palliative Care Programs	
Conduct Medication Management	
Implement/Expand Care Transitions Programs	
Implement Real-Time Hospital-Acquired Infections (HAIs) System	
TOTAL CATEGORY 2 INCENTIVE PAYMENT:	$ 12,861,600.00
Category 3 Domains	
Patient/Care Giver Experience *(required)*	$ -
Care Coordination *(required)*	$ 2,091,375.00
Preventive Health *(required)*	$ 2,091,375.00
At-Risk Populations *(required)*	$ 2,091,375.00
TOTAL CATEGORY 3 INCENTIVE PAYMENT:	$ 6,274,125.00
Category 4 Interventions	
Severe Sepsis Detection and Management *(required)*	$ 1,179,750.00

Central Line Associated Blood Stream Infection Prevention *(required)*	$ 589,875.00
Surgical Site Infection Prevention	$ 589,875.00
Hospital-Acquired Pressure Ulcer Prevention	
Stroke Management	$ 1,769,625.00
Venous Thromboembolism (VTE) Prevention and Treatment	
Falls with Injury Prevention	
TOTAL CATEGORY 4 INCENTIVE PAYMENT:	$ 4,129,125.00
TOTAL INCENTIVE PAYMENT	$ 27,786,506.25

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CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Riverside County Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

Category 1 Summary Page

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

Category 1 Projects

Expand Primary Care Capacity

Process Milestone:	Expand the Family Care Clinic from 16 to 32 rooms.	Yes
Achievement Value		*1.00*
Process Milestone:	Expand primary clinic hours by an additional ten hours per week.	Yes
Achievement Value		*1.00*
Process Milestone:	Implement a mobile health clinic at two sites to increase the community's access to primary care services.	Yes
Achievement Value		*1.00*
Process Milestone:	Increase primary care clinic volume by 3,000 patient visits annually over baseline.	Yes
Achievement Value		*1.00*
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:		$ 6,028,875.00
Total Sum of Achievement Values:		4.00
Total Number of Milestones:		4.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 6,028,875.00
Incentive Funding Already Received in DY:		$ 4,521,656.25
Incentive Payment Amount:		$ 1,507,218.75

Category 1 Summary Page

Increase Training of Primary Care Workforce

Process Milestone:	Increase primary care training by increasing the number of primary care residents by (2).	Yes
Achievement Value		*1.00*
Process Milestone:	In collaboration with the new University of California-Riverside Medical School, expand primary care training by applying for an ACGME residency training program in internal medicine.	Yes
Achievement Value		*1.00*
Process Milestone:	In collaboration with Riverside Community College, expand primary care training rotations for physician assistant students in one primary care clinic by at least an additional (3) students.	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:		$ 6,028,875.00
Total Sum of Achievement Values:		3.00
Total Number of Milestones:		3.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 6,028,875.00
Incentive Funding Already Received in DY:		$ 6,028,875.00
Incentive Payment Amount:		$ -

Category 1 Summary Page

Implement and Utilize Disease Management Registry Functionality

Process Milestone:	Implement a functional disease registry for CHF patients.	Yes
Achievement Value		*1.00*
Process Milestone:	Train at least five more staff on populating and/or using the diabetes and/or CHF registries.	Yes
Achievement Value		*1.00*
Process Milestone:	At least 60% of all known diabetic patients are entered in the registry.	67%
Achievement Value		*1.00*
Process Milestone:	At least 25% of CHF patients are entered in the registry.	Yes
Achievement Value		*1.00*
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:	$ 6,028,875.00
Total Sum of Achievement Values:	4.00
Total Number of Milestones:	4.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 6,028,875.00
Incentive Funding Already Received in DY:	$ 6,028,875.00
Incentive Payment Amount:	$ -

DSRIP Semi-Annual Reporting Form

Category 1 Summary Page

Enhance Interpretation Services and Culturally Competent Care

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

Category 1 Summary Page

Collect Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities

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

Category 1 Summary Page

Enhance Urgent Medical Advice

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

Category 1 Summary Page

Introduce Telemedicine

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

DSRIP Semi-Annual Reporting Form

Category 1 Summary Page

Enhance Coding and Documentation for Quality Data

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

DSRIP Semi-Annual Reporting Form

Category 1 Summary Page

Develop Risk Stratification Capabilities/Functionalities

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

DSRIP Semi-Annual Reporting Form

Category 1 Summary Page

Expand Specialty Care Capacity

Process Milestone:	Launch a new CHF specialty clinic.	Yes
Achievement Value		*1.00*
Process Milestone:	Establish a baseline number of patients to be referred to the CHF Clinic.	Yes
Achievement Value		*1.00*
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	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:		$ 6,028,875.00
Total Sum of Achievement Values:		2.00
Total Number of Milestones:		2.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 6,028,875.00
Incentive Funding Already Received in DY:		$ 3,014,437.50
Incentive Payment Amount:		$ 3,014,437.50

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Riverside County Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

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.*
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The red boxes indicate Total Sums.

Category 2 Projects

Expand Medical Homes

Process Milestone:	Assign at least 25% of eligible patients to a medical home in the Family Care Clinic.	81.5%
Achievement Value		*1.00*
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
DY Total Computable Incentive Amount:		$ 4,823,100.00
Total Sum of Achievement Values:		1.00
Total Number of Milestones:		1.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 4,823,100.00
Incentive Funding Already Received in DY:		$ 4,823,100.00
Incentive Payment Amount:		$ -

DSRIP Semi-Annual Reporting Form

Category 2 Summary Page

Expand Chronic Care Management Models

Process Milestone:	Implement an outpatient diabetic medication titration program supported by pharmacy.	Yes
Achievement Value		*1.00*
Process Milestone:	Implement a peri-operative glucose control program.	Yes
Achievement Value		*1.00*
Process Milestone:	Implement an inpatient glycemic control program to assist patients with poor blood sugar control, targeting patients admitted to the hospital.	Yes
Achievement Value		*1.00*
Process Milestone:	Improve the percentage of diabetic patients who select a self-management goal by 20% over baseline.	20.3%
Achievement Value		*1.00*
Process Milestone:	Expand the number of telephone interactions between diabetic patients and the health care team by an additional 150 calls.	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:		$ 4,823,100.00
Total Sum of Achievement Values:		5.00
Total Number of Milestones:		5.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 4,823,100.00
Incentive Funding Already Received in DY:		$ 4,823,100.00
Incentive Payment Amount:		$ -

Category 2 Summary Page

Redesign Primary Care

Process Milestone:	Train 70% of relevant staff in the Family Care Clinic on methods for redesigning the clinic to improve efficiency.	70.2%
Achievement Value		*1.00*
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Process Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
Improvement Milestone:	-	N/A
Achievement Value		
DY Total Computable Incentive Amount:		$ 4,823,100.00
Total Sum of Achievement Values:		1.00
Total Number of Milestones:		1.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 4,823,100.00
Incentive Funding Already Received in DY:		$ -
Incentive Payment Amount:		$ 4,823,100.00

Category 2 Summary Page

Redesign to Improve Patient Experience

Process Milestone:	Establish a steering committee comprised of organizational leaders, employees, and patients/families to oversee improvements in patient and/or employee experience in the Family Care Clinic.	Yes
Achievement Value		*1.00*
Process Milestone:	Develop a plan to roll out a regular inquiry into patient experience in the Family Care Clinic.	Yes
Achievement Value		*1.00*
Process Milestone:	Train 50% of Family Care Clinic staff on patient experience program goals and objectives.	55.1%
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		
Improvement Milestone:	-	N/A
Achievement Value		
DY Total Computable Incentive Amount:		$ 4,823,100.00
Total Sum of Achievement Values:		3.00
Total Number of Milestones:		3.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 4,823,100.00
Incentive Funding Already Received in DY:		$ 1,607,700.00
Incentive Payment Amount:		$ 3,215,400.00

Category 2 Summary Page

Redesign for Cost Containment

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

Category 2 Summary Page

Integrate Physical and Behavioral Health Care

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

Category 2 Summary Page

Increase Specialty Care Access/Redesign Referral Process

Process Milestone:	Create a plan to redesign the specialty referral process that will address: 1) development of standardized criteria; 2) preliminary work-up/assessment guidelines, and 3) prioritization of specialty care referrals.	Yes
Achievement Value		*1.00*
Process Milestone:	Train 50 staff in Riverside County-based primary and specialty clinics, plus staff in referring clinics regarding new referral guidelines.	Yes
Achievement Value		*1.00*
Process Milestone:	Educate 50 referring primary care physicians on the new referral guidelines.	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:	$ 4,823,100.00
Total Sum of Achievement Values:	3.00
Total Number of Milestones:	3.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 4,823,100.00
Incentive Funding Already Received in DY:	$ -
Incentive Payment Amount:	$ 4,823,100.00

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Riverside County Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

Category 3 Summary Page

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

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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:	$ 4,182,750.00
Total Sum of Achievement Values:	1.00
Total Number of Milestones:	1.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 4,182,750.00
Incentive Funding Already Received in DY:	$ 4,182,750.00
Incentive Payment Amount:	$ -

DSRIP Semi-Annual Reporting Form

Category 3 Summary Page

Care Coordination (required)

Report results of the Diabetes, short-term complications measure to the State (DY7-10)	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:	$ 4,182,750.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	2.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 4,182,750.00
Incentive Funding Already Received in DY:	$ 2,091,375.00
Incentive Payment Amount:	$ 2,091,375.00

Preventive Health (required)

Report results of the Mammography Screening for Breast Cancer measure to the State (DY7-10)	Yes
Achievement Value	1.00
Reports results of the Influenza Immunization measure to the State (DY7-10)	Yes
Achievement Value	*1.00*
Report results of the Child Weight Screening measure to the State (DY8-10)	N/A
Achievement Value	
Report results of the Pediatrics Body Mass Index (BMI) measure to the State (DY8-10)	N/A
Achievement Value	
Report results of the Tobacco Cessation measure to the State (DY8-10)	N/A
Achievement Value	
DY Total Computable Incentive Amount:	$ 4,182,750.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	2.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 4,182,750.00
Incentive Funding Already Received in DY:	$ 2,091,375.00
Incentive Payment Amount:	$ 2,091,375.00

Category 3 Summary Page

At-Risk Populations (required)

Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State (DY7-10)	Yes
Achievement Value	1.00
Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<8%) measure to the State (DY7-10)	Yes
Achievement Value	*1.00*
Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State (DY8-10)	N/A
Achievement Value	
Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State (DY8-10)	N/A
Achievement Value	
Report results of the Pediatrics Asthma Care measure to the State (DY8-10)	N/A
Achievement Value	
Report results of the Optimal Diabetes Care Composite to the State (DY8-10)	N/A
Achievement Value	
Report results of the Diabetes Composite to the State (DY8-10)	N/A
Achievement Value	
DY Total Computable Incentive Amount:	$ 4,182,750.00
Total Sum of Achievement Values:	2.00
Total Number of Milestones:	2.00
Achievement Value Percentage:	100%
Eligible Incentive Funding Amount:	$ 4,182,750.00
Incentive Funding Already Received in DY:	$ 2,091,375.00
Incentive Payment Amount:	$ 2,091,375.00

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Riverside County Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

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:	Participate in the HASC Southern California Patient Safety Collaborative to share data and practices witih other hospitals.	N/A
Achievement Value		*1.00*
Optional Milestone:	Report at least six months of data collection on the Sepsis Resuscitation Bundle to SNI for purposes of establishing the baseline and setting benchmarks.	Yes
Achievement Value		*1.00*
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
DY Total Computable Incentive Amount:		$ 2,359,500.00
Total Sum of Achievement Values:		3.00
Total Number of Milestones:		3.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 2,359,500.00
Incentive Funding Already Received in DY:		$ 1,179,750.00
Incentive Payment Amount:		$ 1,179,750.00

Category 4 Summary Page

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

Compliance with Central Line Insertion Practices (CLIP) (%)		0.99
Achievement Value		1.00
Optional Milestone:	Report at least six months of data collection on the CLIP bundle to SNI for purposes of establishing the baseline and setting benchmarks.	Yes
Achievement Value		*1.00*
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
DY Total Computable Incentive Amount:		$ 2,359,500.00
Total Sum of Achievement Values:		2.00
Total Number of Milestones:		2.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 2,359,500.00
Incentive Funding Already Received in DY:		$ 1,769,625.00
Incentive Payment Amount:		$ 589,875.00

Category 4 Summary Page

Surgical Site Infection Prevention

Rate of surgical site infection for Class 1 and 2 wounds (%)		0.02
Achievement Value		1.00
Optional Milestone:	Report on at least six months of data collection on surgical site infections to SNI for purposes of establishing the baseline and setting benchmarks.	Yes
Achievement Value		*1.00*
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
DY Total Computable Incentive Amount:		$ 2,359,500.00
Total Sum of Achievement Values:		2.00
Total Number of Milestones:		2.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 2,359,500.00
Incentive Funding Already Received in DY:		$ 1,769,625.00
Incentive Payment Amount:		$ 589,875.00

Category 4 Summary Page

Hospital-Acquired Pressure Ulcer Prevention

Prevalence of Stage II, III, IV or unstagable pressure ulcers (%)		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		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
Optional Milestone:	-	N/A
Achievement Value		
DY Total Computable Incentive Amount:		$ -
Total Sum of Achievement Values:		-
Total Number of Milestones:		-
Achievement Value Percentage:		
Eligible Incentive Funding Amount:		
Incentive Funding Already Received in DY:		$ -
Incentive Payment Amount:		

Category 4 Summary Page

Stroke Management

Optional Milestone:	Designate physician(s) to provide 24/7 program coverage.	Yes
Achievement Value		*1.00*
Optional Milestone:	Develop uniform practice standards and protocols to effectively manage and coordinate the stroke program.	Yes
Achievement Value		*1.00*
Optional Milestone:	Designate personnel to establish the multidisciplinary Acute Stroke Team.	Yes
Achievement Value		*1.00*
Optional Milestone:	Train at least 25 multidisciplinary staff on stroke program protocols.	Yes
Achievement Value		*1.00*
Optional Milestone:	Report at least six months of data collection on the seven stroke management process measures to SNI for purposes of establishing the baseline and setting benchmarks.	Yes
Achievement Value		*1.00*
Optional Milestone:	Report the data to the State.	Yes
Achievement Value		*1.00*
DY Total Computable Incentive Amount:		$ 2,359,500.00
Total Sum of Achievement Values:		6.00
Total Number of Milestones:		6.00
Achievement Value Percentage:		100%
Eligible Incentive Funding Amount:		$ 2,359,500.00
Incentive Funding Already Received in DY:		$ 589,875.00
Incentive Payment Amount:		$ 1,769,625.00

Category 4 Summary Page

Venous Thromboembolism (VTE) Prevention and Treatment

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

Category 4 Summary Page

Falls with Injury Prevention

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

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Riverside County Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * Yes

Category 1: Expand Primary Care Capacity

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

Expand Primary Care Capacity

DY Total Computable Incentive Amount:	* $ 6,028,875.00
Incentive Funding Already Received in DY:	* $ 4,521,656.25

Process Milestone: Expand the Family Care Clinic from 16 to 32 rooms.
(insert milestone)

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

This milestone was achieved in September 2011, as documented by the Certificate of Occupancy issued by the Office of Statewide Health Planning and Development. The Family Care Clinic doubled its capacity and added three procedure rooms. The clinic has experienced an increase of nearly 25% in clinic visits per month as a result of this expanded capacity and by extending its hours of operation (as described in the milestone listed below).

There were several reasons for this proposed expansion. Between 2000-2010, Riverside County's population grew by over 40%. In addition, Riverside County had been severely affected by the economic recession. The sustained high unemployment rate had resulted in a steady growth of uninsured individuals seeking care at RCRMC and other county-affiliated providers. Plans were therefore developed to expand the clinic's space to enhance access to primary care services. This additional capacity was also critically needed in anticipation of increased service demand from Low Income Health Program enrollees who would be selecting the Family Care Clinic as their medical home.

Family Care Clinic staff was involved in space planning efforts for the new clinic. Unlike the previous clinic space where residents and attending physicians saw patients in the same area, the expanded space was configured into two separate sections. One would be dedicated to the Family Medicine teaching program where residents, under the supervision of a preceptor physician, would see patients. There would also be an adjoining clinic area where attending physicians would see their patients in a non-teaching environment. In addition to space planning, clinic management developed a staffing plan and training program for the new area. During construction, progress reports were provided to clinic staff on a regular basis through the monthly FCC Wellness staff meetings.

One of the lessons learned from this project is the imprecise predictability of future impacts. For example, even though the implementation of the NextGen electronic health record system was anticipated, it was still difficult to forecast its specific impact, such as insufficient countertop space to accommodate computers needed for the system. Another key lesson learned is that the creation of additional capacity can provide the opportunity to address future problems. As a consequence of the lengthy, deep recession in Riverside County, demand for Emergency Department services increased, resulting in serious overcrowding. The availability of additional Family Care Clinic capacity has facilitated program planning to identify new service options to provide an alternative to Emergency Department usage for patients with less acute conditions.

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

Category 1: Expand Primary Care Capacity

Process Milestone: Expand primary clinic hours by an additional ten hours per week.
(insert milestone)

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

This milestone, which pertains to the Family Care Clinic, was achieved as of July 2011. The achievement is documented by the clinic schedule and a report that outlines the expansion of clinic hours presented at the Medical Executive Committee in October 2011.

Prior to 2011, the Family Care Clinic's hours of operation had been Monday-Thursday from 8am to 6:30pm, Fridays from 8am to 5pm, and Saturdays from 8am to 2pm. The clinic further expanded its hours to meet the needs of patients requiring services in the evening and on weekends. In May 2011 evening hours on Mondays-Thursdays were extended to 8pm (+6 hours/week) and the clinic began offering evening hours on Fridays from 5pm to 8pm (+3 hours/week). In June 2011 the Family Care Clinic introduced services on Sundays from 8am to 12pm (+4 hours/week). In July 2011 the clinic's Saturday hours were extended until 4pm (+2 hours/week). In summary, the Family Care Clinic has extended its hours by 15 additional hours per week.

The decision was made to extend the clinic's hours of operation so that services could be more convenient for patients, especially those who work during the day. The expanded hours have also allowed the clinic to function similarly to an urgent care center for patients who have less acute medical issues. Given current patient demand, there are plans to extend Sunday hours beyond 12:00 pm to 4:00 pm.

One of the project's challenges has been the ability to maintain consistent staff coverage for these extended hours. This issue has been addressed by modifying the staffing schedule to include an 11:30am – 8:00pm shift.

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

Category 1: Expand Primary Care Capacity

Process Milestone: Implement a mobile health clinic at two sites to increase the community's access to primary care services.

(insert milestone)

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

This milestone was achieved prior to July 2011, as documented by the mobile clinic site schedule. The program was implemented at four sites: Edgemont Elementary School in the Moreno Valley School District on 2/23/11; Harvest Valley Elementary School in the Romoland School District on 3/15/11; Ortega High School in the Lake Elsinore School District on 3/10/11; and Machado Elementary School, also in the Lake Elsinore School District on 3/17/11.

Riverside County, with a population of over 2.2 million, is the fourth most populous county in California. Geographically, it is also one of the largest in the state, covering nearly 7,300 square miles which makes it nearly the same size as New Jersey. Health care providers tend to cluster around the urban, populated areas of the county. As a result, a serious health care access issue exists for many Riverside County residents, especially those who are low income or uninsured. This lack of health care access contributes to the county's relatively higher hospitalization rates for preventable conditions, and to its significantly lower ranking on various health status measures when compared to the other 58 counties in California (according to the California Department of Public Health's "County Health Status Profiles - 2011" and the Office of Statewide Health Planning and Development's "Preventable Hospitalizations in California: Statewide and County Trends 1999-2008").

This mobile health clinic is an extension of the Riverside County community-based schools program that was launched in August 2009 to address this health care access issue. Riverside County establishes partnerships with local school districts and community organizations to provide primary care services to low income, underserved communities throughout Riverside County. A health care team, comprised of a nurse practitioner, pharmacist, licensed vocational nurse, and support staff, work under the supervision of a Family Medicine physician. The team provides medical examinations, immunizations, and other primary care services to individuals and families. They visit each site on a regular basis during the month according to a schedule that is developed by Riverside County in collaboration with the school district or community organization.

The effectiveness of the mobile clinic program is evaluated in several ways. First, for new sites, an evaluation survey is sent to the school district and/or community organization site administrator as applicable who works with the mobile health clinic team on this program. The survey's purpose is to assess whether the clinic's services, hours of operation, and site location are meeting the needs of the target patient population. Based on survey results, changes are made as needed. On an annual basis, each school district and/or community organization representative is sent an on-line satisfaction survey to evaluate overall satisfaction with the mobile clinic's services, identify potential new services to meet community need, identify barriers that may be preventing clients from accessing services, assess courtesy of staff and cleanliness of the mobile clinic, and determine, what improvements, if any, should be made to the mobile clinic's services.

In October 2011 administration of a patient satisfaction survey was initiated. The surveys are available in both English and Spanish. Patients are asked to rate their overall satisfaction with the mobile clinic program; identify where they would have gone for care if the mobile clinic services were not available; indicate their preference for walk-in or scheduled appointments; and identify types of services they would like offered. The mobile clinic staff estimates the survey return rate averages about 50%. Survey results indicate that patient satisfaction is high, usually above 80%. Patients prefer walk-in availability rather than scheduled appointments. If mobile clinic services were not available, over 50% of patients stated they would seek care at a community clinic or not seek care at all.

The success of the mobile clinic is also being measured by how it is increasing patient access to services and improving the population's health. Between April 2011 and July 2012, there have been 4,022 patient visits. A total of 1,033 immunizations have been administered to 729 patients at the program's established sites. In addition, the program has set up separate clinics to address specific community needs. For example, 14 immunization clinics were launched for the three month period between June-August 2011 to provide the mandated Tdap vaccines to school children. Another example is the Saturday immunization clinics held twice a month at RCRMC. Through these special clinics an additional 1,285 patients have received 2,367 immunizations.

Many patients, especially those with chronic conditions such as diabetes, are using the mobile clinic as their medical home. In October 2011, mobile clinic staff started tracking results of 23 diabetic patients who consistently receive care through the mobile clinic and who have had at least two HbA1c values. Thirteen patients, with a baseline HbA1c > 9%, have experienced a reduction of 25% in their glucose level to 7.9% on average over a four month period. Ten patients, with a baseline HbA1c > 10%, have seen a 40% reduction in their glucose level to 6.9% on average over a four month period. The mobile clinic staff will be considering the expansion of clinical measures in the future. In summary, satisfaction surveys, utilization data, and clinical measures are being used to assess the success of this program.

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

Category 1: Expand Primary Care Capacity

Process Milestone: Increase primary care clinic volume by 3,000 patient visits annually over baseline.

(insert milestone)

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

This milestone, which pertains to the Family Care Clinic, was achieved by April 2012 as documented by the hospital's Monthly Executive Management Report. The baseline number of clinic visits, established between July 2009-June 2010, was 20,662. As of April 2012, the total number of visits was 25,229. This increase in clinic volume was achieved largely due to the achievement of two other milestones noted in this plan which included doubling the Family Care Clinic's capacity and expanding its hours of operation.

The clinic is expected to continue its growth in utilization due to a number of factors, including the implementation of the Low Income Health Program and programs which target specialized patient populations. As an example, a clinic designed for people with disabilities, who are high utilizers of health care services, is being launched to provide more comprehensive management of these patients. Clinic volume may also increase as a result of current program planning efforts to identify how the Family Care Clinic can assist in reducing Emergency Department utilization.

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: Riverside County Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * Yes

Category 1: Increase Training of Primary Care Workforce

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

Increase Training of Primary Care Workforce

DY Total Computable Incentive Amount: * $ 6,028,875.00

Incentive Funding Already Received in DY: * $ 6,028,875.00

Process Milestone: Increase primary care training by increasing the number of primary care residents by (2).
(insert milestone)

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

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

This milestone was achieved in July 2011 as evidenced by the list of enrolled residents. RCRMC's Family Medicine Residency Program has traditionally matriculated nine new residents per year. The training program, which is three years in length, had a baseline number of 27 residents. RCRMC sought to increase the number of residency positions to address the severe shortage of primary care physicians in Riverside County. According to the June 2009 California HealthCare Foundation report "Fewer and More Specialized: A New Assessment of Physician Supply in California," Riverside County has approximately 36 primary care physicians per 100,000 population which falls below a benchmark of 60-80 primary care physicians per 100,000 population, as established by the Council on Graduate Medical Education. The report also cites that Riverside County is the only county with a population above 1 million people that has fewer than 100 physicians per 100,000 population.

RCRMC's submitted a formal request to the Accreditation Council for Graduate Medical Education to increase the number of Family Medicine residency positions by two positions. As of July 1, 2011, the number of first-year residents increased from 9 to 11, bringing the total number of residents enrolled in the RCRMC's Family Medicine program to 29.

One of the challenges in coordinating a residency training program is to ensure that there are a sufficient number of preceptor physicians to supervise the residents. Due to the expansion of the Family Care Clinic, additional physicians were hired as part of the clinic's physician panel. Some are also serving as supervisors for the new residents. Another challenge is to have a sufficient number of training sites. Given the size of RCRMC's training program, the residents are not all able to practice at the Family Care Clinic. Therefore, two of the county's family health center sites are serving as continuity clinic training locations for the Family Medicine residents.

To address the critical physician shortage, RCRMC seeks to retain resident physicians after they complete their training, either within the county's health care system or with other providers in the county. One of the criteria used to select residency candidates is the individual's interest in serving low income, vulnerable populations. As a result, the majority of graduates practice in areas of unmet need and about 50% of Family Medicine graduates continue to practice in either the Riverside or San Bernardino area.

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

Category 1: Increase Training of Primary Care Workforce

Process Milestone: In collaboration with the new University of California-Riverside Medical School, expand primary care training by applying for an ACGME residency training program in internal medicine.

(insert milestone)

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

This milestone was achieved in November 2011, as documented by the submission of the internal medicine residency application to the Accreditation Council on Graduate Medical Education (ACGME) on 11/7/11. Thirty six resident positions were requested. The ACGME conducted a site review at RCRMC in January 2012. The application was approved in May 2012. Applicant interviews will begin in October 2012 and the residency program will officially launch in July 2013.

The internal medicine residency training program will feature residents working with diverse patient populations in a variety of teaching clinic environments. It will be distinctive in its structure, focusing on training primary care physicians in the ambulatory care setting. The program will be based upon the maximum allowable outpatient experiences allowed by the ACGME Resident Review Committee for Internal Medicine. Residents will spend nearly 70% of their training in the outpatient setting.

In addition, the training program will offer a “community care” project in which the resident will develop a project in collaboration with a clinical site to improve the patient care or clinic system. A key goal of this training program will be to attract and train physicians who are interested in practicing primary care in Riverside County. In general, the location of residency training programs significantly contributes to where physicians eventually practice and the intent is to train physicians to address the critical primary care physician shortage in Riverside County.

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

Category 1: Increase Training of Primary Care Workforce

Process Milestone: In collaboration with Riverside Community College, expand primary care training rotations for physician assistant students in one primary care clinic by at least an additional (3) students.

(insert milestone)

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

This milestone was achieved by July 2011, as documented by the student rotation schedule. RCRMC and Riverside Community College (RCC) jointly operate a physician assistant program. Fifteen students have traditionally rotated through RCRMC's clinics as part of their training program. In the March 2012 report it was stated that, during the August 2010-July 2011 academic year, the number of physician assistant students rotating through this program was increased by four, bringing the total number to 19 students. However, since reporting this information, RCRMC staff has determined that three additional students should have been included on the student rotation list. Therefore, the actual number of students increased by seven, bringing the total number to 22 students.

This physician assistant training program will help address the critical shortage of primary care physicians in the Riverside County. Physician assistants play an important role in the patient-centered medical home. They can help physicians be more efficient by addressing routine patient care needs and allowing physicians to address more complex medical issues. One of the key concepts taught during their training is the importance of multidisciplinary team-based care. They learn how to communicate and interact with other members of the team. To help prepare physician assistant students for their training rotations, four RCRMC pharmacists have become adjunct faculty at Riverside Community College and teach the first year Pharmacology class for students. This interaction better prepares the student to work with pharmacists in the clinic when they arrive at RCRMC for training during their second year.

There have not been any significant challenges in managing this training program. One of the keys to a successful program is the ability for program administrators to properly balance the student's education with training requirements, e.g., work hours, site locations to accommodate class size, etc., to maximize the learning experience for each student.

In addition to increasing the number of students trained, the clinical scope of physician assistants has also been expanded through the establishment of a Physician Assistant Mental Health Fellowship which is a partnership between RCRMC, Riverside County Department of Mental Health, and RCC. This program, which is the first physician assistant fellowship program with a psychiatric focus established in California, will help facilitate the integration of physical medicine and behavioral health services which will better serve patients.

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: Riverside County Regional Medical Cente
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * Yes

Category 1: Implement and Utilize Disease Management Registry Functionality

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

Implement and Utilize Disease Management Registry Functionality

DY Total Computable Incentive Amount: * $ 6,028,875.00

Incentive Funding Already Received in DY: * $ 6,028,875.00

Process Milestone: Implement a functional disease registry for CHF patients.
(insert milestone)

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

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 congestive heart failure (CHF) registry was established in November 2011, as documented by the registry's patient data summary report. Patients were initially entered in the registry based on the following criteria: they had at least one RCRMC clinic visit during the past year with an ejection fraction of 40% or less, as identified by an echocardiogram. Additional information captured in the registry includes, but is not limited to, blood pressure, patient medications, and co-morbidity information.

The registry's technical configuration is being upgraded to increase its value as a clinical tool. The registry, which requires manual data entry, was originally designed as an Access database that operated on one desktop computer. Its information will now be stored on the hospital's computer server which allows clinicians to access the registry from any computer. The CHF Clinic's nurse practitioner and cardiologist worked with the hospital's information services staff to help design the new database. Data fields will capture information to facilitate more effective care coordination. Examples include: lab test results (basic metabolic panel, brain natriuretic peptide, lipid panel, HbA1c, and liver panel); diagnostic test results such as echocardiograms or electrocardiograms; and whether the patient has an automatic internal cardiac defibrillator (AICD). The new registry will still require manual data entry. However, with its redesign, clinicians will be able to directly access as well as enter information in the registry during the clinic visit by using laptop computers. The hospital's information services team has completed testing of the new system. The CHF Clinic staff is in the process of being trained on the use of the registry. Information Services staff will provide support after training has been completed to answer staff questions on the use of the new system. Demonstrated competency on the use of the registry will also be part of employee annual evaluations.

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

Category 1: Implement and Utilize Disease Management Registry Functionality

Process Milestone: Train at least five more staff on populating and/or using the diabetes and/or CHF registries.

(insert milestone)

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

This milestone was achieved by November 2011. Five staff members were trained on the use of the diabetes registry which requires manual data entry. They included a nurse practitioner, registered nurse, and two health service assistants who work in the Diabetes Management Clinic. A data analyst who works in the Family Care Clinic was also trained on the use of the registry. The staff was tested on their competency in using various features of the registry, including entering different types of data and producing data reports. These competency checklists serve as documentation that this milestone was achieved.

Training is being reinforced in several ways. A supervisor who provides administrative oversight to data entry staff is available to answer questions and provide assistance as needed. A registry user guide is also available as a reference tool. Demonstrated competency on the use of the registry will also be part of the employee's annual evaluation.

A process has been established to ensure the accuracy of information entered in the registry. The supervisor is responsible for performing audits to validate data accuracy. One involves the review of lab results, such as HbA1c data. The values entered in the registry are randomly checked to identify any unexplained outliers which fall outside of normal ranges. Information entered in error can be traced back to a specific medical record and corrections are made. Patient charts are also audited on a random basis to assess whether lab test values and other pertinent clinic visit data have been entered correctly in the registry. When errors are found, they can be traced to the staff person who entered the information. These errors are documented and additional training is provided to the individual.

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

Category 1: Implement and Utilize Disease Management Registry Functionality

Process Milestone: At least 60% of all known diabetic patients are entered in the registry.
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	1,506.00
Denominator (if absolute number, enter "1")	*	2,252.00
Achievement		67%
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

This milestone was achieved in September 2011. Milestone achievement is documented by the: 1) diabetes registry report which lists the number of patients entered in the registry and 2) medical records report which lists the number of known diabetic patients seen in the Family Care Clinic since July 2010. The baseline number of diabetic patients in the registry, as of June 2010, was 702 patients out of 1,682 known diabetic patients in the Family Care Clinic, or 42%. As of 9/30/11, 67% of known diabetic patients were included in the registry.

The diabetes registry is undergoing a change in its technical configuration similar to the CHF registry to increase clinician accessibility to the system's information. However, the registry still requires manual data entry. Due to the large volume of diabetic patients seen in the clinic, a key challenge is to maintain current patient information in the registry. The registry information is critical for care coordination and performance improvement. Therefore, additional staff resources have been launched to update information in the diabetes registry so it reflects current information on all new and existing diabetic patients. Future plans include the purchase of the i2iTracks Population Health Management System to assist RCRMC's transition to a more population health focus and to meet the needs of a growing diabetes patient population.

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	*	60%
Achievement Value		1.00

Process Milestone: At least 25% of CHF patients are entered in the registry.
(insert milestone)

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

This milestone was achieved by December 2011, as documented by: 1) the registry's patient data summary report and 2) a report which lists the number of CHF patients who had clinic visits during the past year and an ejection fraction of 40% or less. Information was manually entered on 100% of identified CHF patients.

Given that the registry requires manual data entry, the key challenge will be the ability of CHF Clinic staff to keep the patient information in the registry current as new patients are seen in the CHF Clinic as well as updating data on existing patients. Clinic management is in the process of identifying additional staff resources that will have the primary responsibility of managing the CHF registry.

To ensure the accuracy of the information entered in the registry, CHF Clinic staff will perform a random audit of ten patient visits recorded in the registry on a quarterly basis for data accuracy. Information will be verified through the clinic medical record, dashboards, and other databases which report specific CHF-related values and results.

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 (DSRIF
DPH SYSTEM: Riverside County Regional Medical Cente
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * Yes

Category 1: Expand Specialty Care Capacity

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

DY Total Computable Incentive Amount: * $ 6,028,875.00

Incentive Funding Already Received in DY: * $ 3,014,437.50

Process Milestone: Launch a new CHF specialty clinic.
(insert milestone)

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

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 Congestive Heart Failure (CHF) Clinic was launched in August 2011, as documented by the clinic schedule. According to the Riverside County Department of Public Health, heart disease accounts for nearly 30% of all deaths in Riverside County. CHF represents one of the most common discharge diagnoses at RCRMC. During the first quarter of 2012 alone, there were 112 patients with a primary diagnosis of CHF. Historically, many CHF patients have been unable to receive timely and appropriate outpatient follow-up care once discharged from the hospital. Delays in the transition of care from inpatient to the outpatient setting have contributed to increased readmission rates.

The CHF Clinic was implemented to address this gap in the continuum of care and to standardize care processes. All patients are receiving treatment according to evidence-based practices known to reduce hospitalization and mortality. A multidisciplinary team approach is used in the clinic. This team is anchored by a nurse practitioner who works under the supervision of a cardiologist. Other team members include a CHF nurse, case manager, and dietician. Among her responsibilities, the nurse practitioner visits all inpatients with a primary diagnosis of CHF prior to discharge to ensure their management is appropriate per evidence-based guidelines and to coordinate the scheduling of an appointment in the CHF Clinic within one week of the patient's discharge. She also contacts patients by telephone between clinic visits to check on the patient's condition and address any CHF-related issues.

The success of the CHF Clinic will be measured by various CHF outcome measures, including:

• Number of CHF patients who were readmitted to RCRMC within 30 days with a primary diagnosis of CHF.
Data from the 1st quarter of 2012 indicate RCRMC had a lower readmission rate (9.3%) compared to the University HealthSystem Consortium (UHC) benchmark of 10.5%.

• Number of CHF patients who were readmitted to RCRMC within 30 days with any diagnosis.
Data from the 1st quarter of 2012 indicate a lower percentage of patients were readmitted to the hospital with a secondary diagnosis of CHF (18.2%) in comparison to the UHC benchmark of 20.9%.

• Number of CHF patients with a primary diagnosis of CHF who received a clinic appointment at RCRMC within 7 days of discharge.
Data from the 2nd quarter of 2012 show 88% of patients received an appointment within one week of discharge as compared to the internal goal of 95%. This result is a significant improvement over baseline data of 40%-50% from 2009-2010 which, at that time, pertained to the Cardiology Clinic. The baseline data contributed to identifying the need to establish a CHF Clinic to provide more timely care to CHF patients being discharged from the hospital.

Additional outcome measures will be used, including the percentage of patients who obtain New York Heart Association (NYHA) functional class II or better. As noted below, this system includes a four point scale by which to evaluate the functional status of CHF patients:
• Class I: Cardiac disease, but no symptoms and no limitation in ordinary physical activity, e.g. shortness of breath when walking, climbing stairs etc.

• Class II: Mild symptoms (mild shortness of breath and/or angina) and slight limitation during ordinary activity.

• Class III: Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g., walking short distances; comfortable only at rest.

• Class IV: Severe limitations. Experiences symptoms even while at rest.

Other outcome measures include: average time required to obtain optimal CHF medical management; percentage of patients that receive an automatic internal cardiac defibrillator (AICD) implantation who qualify based on current guidelines; percentage of patients who obtain standard diagnostic testing (including BUN/Creatinine, potassium level, lipid profile, electrocardiogram, echocardiogram - to access the ejection fraction); percentage of patients on core CHF medications (such as ACE inhibitors, beta blockers, etc.); and number of CHF-related Emergency Department visits.

Data for many of these measures will be tracked through the redesigned registry referenced in this report. Other measures, however, will be tracked once a more robust information system is available, e.g., implementation of the NextGen electronic health record and the i2i Tracks Population Health Management System.

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

Achievement Value 1.00

Category 1: Expand Specialty Care Capacity

Process Milestone: Establish a baseline number of patients to be referred to the CHF Clinic.
(insert milestone)

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

This milestone was achieved by June 2012. Baseline data pertaining to the number of CHF Clinic patients seen was gathered by the nurse practitioner and CHF nurse between August 1, 2011 and December 31, 2011 as documented by the clinic schedule. The CHF Clinic was operational two half-days per week (Mondays and Tuesdays). A total of 173 patients were seen during the approximate 21.5 weeks in the time period, or an average of eight patients per week. This baseline number may have been impacted by the patient no-show rate of 34%. To reduce this no-show rate, CHF Clinic staff have been calling patients and/or sending reminder post cards in the mail.

Beginning in DY 8, milestones pertaining to increasing the number of CHF referrals per week will be measured against this baseline number of eight patients. It is believed that most patients hospitalized with severe CHF are being seen in this clinic for follow up care post-discharge which has positively impacted the reduction in the CHF readmission rate. RCRMC is looking beyond its original DSRIP goal, which focused on CHF hospital inpatients, to partner with community federally qualified health centers (FQHCs) in Riverside County to seek additional patient referrals to the CHF Clinic.

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 (DSRIF
DPH SYSTEM: Riverside County Regional Medical Cente
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * Yes

Category 2: Expand Medical Homes

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

DY Total Computable Incentive Amount: * $ 4,823,100.00

Incentive Funding Already Received in DY: * $ 4,823,100.00

Process Milestone: Assign at least 25% of eligible patients to a medical home in the Family Care Clinic.
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * 4,074.00

Denominator (if absolute number, enter "1") * 4,998.00

Achievement 82%

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

This milestone was achieved by December 2011, as documented by a report which lists the number of adult patients with two or more Family Care Clinic visits between July 2010 and June 2011 who were assigned to a clinic physician. There were 4,998 adults patients seen at least twice in the clinic during this timeframe who were eligible for medical home assignment. Of this total, nearly 82% were empanelled with a primary care physician.

Medical home assignment was based on the following criteria: 1) Patients are assigned to the primary care provider with whom the patient has had the most visits, unless indicated otherwise by patient preference; 2) If a patient has been seen an equal number of times by more than one physician and no one provider has conducted the majority of visits, the patient will be assigned to the provider who has conducted the most recent visit; 3) Primary care provider assignment may include resident physicians; an attending physician from the resident's health care team will also be assigned to that patient and provide oversight to the resident; and 4) Patients have the option of choosing their own primary care provider as long as the provider's panel is still open.

Clinic management is currently assessing the extent to which patients are consistently being seen by their assigned provider. The goal is at least 60% of the time. Currently, the average is no greater than 40% of the time. This result is due to a number of factors. Some patients are assigned to residents who work in the clinic only one or two half-days per week which contributes to the lack of available appointment slots with the patient's provider. In addition, clinic schedulers do not always have access to the empanelment information. Continuity is higher for patients assigned to an attending physician because they work in the clinic every day and patients schedule their appointments directly with their provider.

Different interventions are being discussed to address these issues. Patient continuity data will be collected on a regular basis for ongoing monitoring and follow up by adding a data field to the clinic provider productivity report. In addition, there are plans to transition to a centralized scheduling system where schedulers designated for the Family Care Clinic would have access to the physician's patient panel. Another strategy is to appoint an empanelment coordinator who will be responsible for monitoring patient continuity and managing the number of patients assigned to a provider panel to ensure that the panel size does not grow too large.

With regard to developing a patient-centered medical home (PCMH), the Family Medicine physician champion met twice a week with clinic physicians, licensed vocational nurses, and health services assistants to educate them about this model of care. A pilot program was initially established with one provider team. The team members, together with the clinic manager and a hospital administrator, have been participating in a Safety Net Institute Medical Home Collaborative with other public hospitals. Through this project they have participated in learning sessions, webinars, conference calls, and health coach training sessions.

In order to establish best practices with regard to medical home implementation and spread, three additional primary care providers and their teams have joined the medical home pilot program. Each provider and their team has had one half day of administrative time each week to discuss and implement quality improvement using the Plan-Do-Study-Act (PDSA) cycle. One process improvement was to improve the clinic's no-show rates. Letters were sent and phone calls made to patients to remind them of their clinic appointments or to complete any necessary laboratory or diagnostic tests. As a result, the no-show rate decreased from an average of 30% to less than 10%. Another improvement process pertained to the "check in" process. With the Family Care Clinic expansion, a new process was implemented. Front desk personnel were cross-trained to perform a combination of greeting the patient, registration, and check-in duties so patients could stand in one rather than two lines. Other examples of process improvement initiatives include medication reconciliation workflow and telephone calls to reinforce self-management goals.

As stated previously, each medical home team meets weekly to discuss tests of change and modifications to previous tests of change. Although these meetings have been beneficial to each medical home pilot team, the four teams have traditionally met at separate times (e.g., medical home pilot team A meeting on Wednesday afternoons and medical home pilot team B meeting on Friday afternoons). There has not been a formal process for sharing quality improvement successes among medical home teams. Therefore, starting in October 2012, the medical home pilot teams will be meeting as a larger group on a regular basis to spread ideas and develop shared group practices.

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: Riverside County Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * Yes

Category 2: Expand Chronic Care Management Models

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

DY Total Computable Incentive Amount: * $ 4,823,100.00

Incentive Funding Already Received in DY: * $ 4,823,100.00

Process Milestone: Implement an outpatient diabetic medication titration program supported by pharmacy.
(insert milestone)

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

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

This milestone was fully implemented by December 2011, as documented by reports presented to the hospital's Performance Improvement Committee in December 2011. This program was established to address the following problems: 1) persistent uncontrolled diabetes (HbA1c >9%) in RCRMC's outpatient population; 2) insufficient monitoring, follow up, and/or education provided to diabetic patients which contributed to worsening patient outcomes; and 3) patients with uncontrolled diabetes were unable to be seen for follow up in a timely manner. Clinicians from the Family Care and Internal Medicine Clinics, including physicians, pharmacist, nurse practitioners, nurses, nutritionist, health service assistants, and medical and pharmacy students came together to address these issues. From this group a core team of physicians and the pharmacist developed a protocol for collaborating together in the care of diabetic and hyperglycemic patients, which resulted in adding clinical pharmacists to patient care teams to provide glucose management consultation by referral.

In establishing the outpatient medication titration program, the following steps were taken: 1) current barriers to glycemic control were identified; 2) outcome metrics were defined and established; 3) policies and guidelines for standardized recommendations for interventions, and initiation and titration of insulin were developed; 4) increased frequency of patients visits with titration and monitoring was implemented; and 5) a mixed model of care was used, including clinic visits and phone calls to patients between visits.

Best practices for targeted glycemic control were established that include standardized protocols; criteria for glucose management consultations; accurate documentation of hyperglycemia; initial patient assessment; management plan; target blood glucose range; frequency of blood glucose monitoring; maintenance of glycemic control.

Current patient outcomes for the Family Medicine and Internal Medicine Clinics, as of 2012 YTD are:
• Average percentage reduction of HbA1c from baseline to last HbA1C (0 – 3 months from baseline): Goal: >15%; Result: Achieving goal – mostly greater than 17%

• Average percentage reduction of HbA1c from baseline to last HbA1c (3-6 months from baseline): Goal: >25%; Result: Approaching goal: 23%

• Average percentage reduction of HbA1c from baseline to last HbA1c (6-12 months from baseline): Goal: >25%; Result: Approaching goal: 28%

• Percentage of diabetic patients who achieved an HbA1c <8 after 6 months of treatment: Goal: >50%; Result: Approaching goal: 40%

• Percentage of diabetic patients who are followed by phone management: Goal: >30%; Result: Consistently achieving more than 50% of visits via the telephone, including Spanish language visits.

One lesson learned from this project is the importance of reinforcing consultation referral criteria. Some patients with an average HbA1c <9% have been referred to the pharmacist which can decrease accessibility for those patients with uncontrolled diabetes and skew the program's patient care outcomes data. Additional attention will be given to scheduling th appropriate patients for the glucose management consultation. Another lesson learned is that the clinical pharmacist can often achieve similar glycemic control outcome goals as mid-level practitioners in a shorter period of time because they are able to see patients more often for a brief follow up visit which can assist patients in achieving their goals more quickly. Key findings from this project may be helpful to other organizations which have or will be undertaking a similar initiative.

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

Achievement Value 1.00

Category 2: Expand Chronic Care Management Models

Process Milestone: Implement a peri-operative glucose control program.
(insert milestone)

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

This milestone was fully implemented in December 2011, as evidenced by a report presented to the Medical Executive Committee in January 2012. The peri-operative glucose control program was implemented in phases (pre-operative, intra-operative, and post-anesthesia care unit stages) between April and December 2011. The program was launched to address the following issues: 1) uncontrolled (low or high) blood glucose levels for patients, including those scheduled for surgery; 2) reduce the potential for poor diabetes-related surgical outcomes, including surgical site infections and delayed healing; and 3) decrease delays and/or cancellations of surgeries due to severe hyperglycemia which impacts the entire surgery schedule and operating room patient throughput.

Patients were being scheduled for surgery without knowledge of their diabetes status, including level of glucose control, their HbA1c status, etc. In addition, surgical patients were often scheduled for surgery with incomplete orders or instructions on how to manage their insulin and oral anti-diabetic medications in the pre-operative period. This lack of information resulted in patients presenting to the operating room with extremely uncontrolled blood glucose levels. Protocols in the operating room and same day surgery (SDS) department for hyper/hypoglycemia management were also outdated. To address these problems, a pharmacist worked in the pre-op clinic to review, educate, and provide detailed instructions to patients on anti-diabetic medications for the day preceding their surgery as well as the day of surgery. Instruction forms and evidence-based protocols for insulin dosing was also implemented. In addition, guidelines were developed for SDS related to monitoring and providing interventions for patients' blood glucose levels. The Anesthesia Department established additional monitoring and intervention protocols for peri-operative use.

Listed below are the target outcomes/benchmarks that have been established for this program. In addition, the 2012 year-to-date results are included:
• Percentage of diabetic patients with HbA1c drawn prior to surgery (within 2 months): Benchmark: >70%; Baseline: 40%. 2012 YTD: 91%.

• Percentage of surgical patients with HbA1c >8%: Benchmark: <30%; Baseline: 43%. 2012 YTD: 53%

• For SDS patients, percentage of blood glucose <70 mg/dL on first point of care (POC) glucose in the pre-op holding area: Benchmark: <5%; Baseline: 1%; 2012 YTD: 0.046%.

• For SDS patients, percentage of blood glucose >180 mg/dL on the first point of care (POC) glucose in the pre-op holding area: Benchmark: <10%; Baseline: 25%. 2012 YTD: 21%.

• Percentage of blood glucose < 70 mg/dL on first POC glucose in post-anesthesia care unit: Benchmark: <5%; Baseline: 0%; 2012 YTD: 0.015%

• Percentage of blood glucose >180 mg/dL on first POC glucose in the post-anesthesia care unit: Benchmark: <10%; Baseline: 27%; 2012 YTD: 31%.

Improvement in the percentage of patients with HbA1c tests completed within two months of surgery is attributed to the pharmacist who began ordering HbA1c tests for patients who didn't have one ordered. In addition, improved lab test forms have helped increase the number of HbA1c tests ordered. Future steps include the pharmacist working with the surgical and orthopedic clinic staff to implement HbA1c ordering prior to scheduling surgery. With regard to the percentage of surgical patients with uncontrolled diabetes, surgeons/providers are being notified if their patient's HbA1c value is >8% to determine if the surgery can be performed safely or if elective surgeries can be rescheduled until the glucose is controlled. In addition, POC HbA1c testing equipment is now used in the surgical clinics to identify high risk diabetic patients prior to scheduling surgery.

Very few SDS patients are arriving on the day of surgery with hypoglycemia which may be due to improved case review and calls made to patients prior to surgery to confirm medication instructions. The number of SDS patients who arrive on the day of their surgery with hyperglycemia is higher than the internal benchmark, but lower than the baseline value by 16%. The larger than expected number of patients with peri-operative hyperglycemia is likely due to the large number of poorly controlled diabetics in our surgical patient population, many of which are on oral diabetic medications but require more aggressive insulin therapy to achieve better control. Efforts and protocols will be developed and implemented in the SDS to address this issue. Cases will also be reviewed with pharmacists to refer patients to their primary care physician or RCRMC's Diabetes Clinic prior to surgery in an attempt to optimize the patient's treatment program prior to surgery. Efforts will also focus on expanding the use of pre- and intra-operative insulin protocols, which will ultimately improve glucose control in the post-anesthesia unit.

A key lesson learned is that the project should have broad multidisciplinary participation from anesthesia, surgeons, nurses, pharmacists, pre-op staff, and schedulers. The identification of a physician champion for the program is also critical. An anesthesiologist played this role which was beneficial in uniting surgeons and internists. In addition, the phased approach to program implementation did not provide as much impact towards program success as expected. More time was also needed to review and develop policies which addressed the entire program rather than a specific stage of the peri-operative glycemic

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

Category 2: Expand Chronic Care Management Models

Process Milestone: Implement an inpatient glycemic control program to assist patients with poor blood sugar control, targeting patients admitted to the hospital.

(insert milestone)

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

This milestone was achieved by November 2011. A pilot inpatient glycemic control program was implemented on the 4500 medical inpatient nursing unit, as documented by a report presented to the hospital's Performance Improvement Committee in December 2011. This program was established to address the issue of persistent uncontrolled blood glucose in the inpatient setting throughout the patient stay. This problem was not being addressed due to various factors. Diabetes/hyperglycemia was often overlooked during admission and hospitalization because it was not a primary reason for admission. In addition, traditional protocols, including clinician over-dependence on Insulin-Sliding Scales, were being followed which resulted in a more reactive rather than aggressive approach to treating the patient's uncontrolled diabetes. There was lack of staff knowledge about proactive ways to treat patients with uncontrolled diabetes. There were also no standardized protocols for glycemic control or a dedicated diabetes team to work with inpatients.

A core inpatient glycemic control team, comprised of a physician champion, clinical pharmacist (also a certified diabetes instructor), unit nurse manager, and two diabetes nurse specialists, was created to initiate program planning. Performance improvement was completed through a Failure Mode Effects Analysis (FMEA) process. Baseline data related to HbA1c, hyperglycemia incidence, and other measures, were collected on the planned pilot unit. The team also worked on program development, including establishing policies, protocols and defining metrics. Among the protocols developed were standardized insulin order sets and providing accurate documentation of hyperglycemia. Within 48 hours of admission, the initial patient assessment would be completed and glycemic control would be added to the problem lists for nursing and pharmacy for patients who had blood sugars <70 mg/dL or >180 mg/dL. For these uncontrolled patients, the inpatient glycemic control team would see the patient and provide recommendations to initiate or adjust insulin therapy using the standardized order set. Inservice education was conducted for physicians, nurses, pharmacists, and students, addressing the glycemic control program goals, diabetes complications, and optimal glucose management targets.

In April 2012 the program was rolled out to a second inpatient unit (3500-Surgical Specialty), following the same methodology as the initial pilot. Listed below are the program's target performance measures:

• >80% of diabetic patients with HbA1c during, or within, 2 months of admission;

• >80% of hyperglycemia patients on the "Adult Inpatient Subcutaneous Insulin Protocol;"

• <30% of inpatients with average glucose >180 mg/dL throughout the admission;

• <10% of inpatient days with extreme hyperglycemia (blood glucose >300 mg/dL);

• <10% of inpatient days with hypoglycemia (blood glucose < 70 mg/dL; and

• 15% reduction in the length of stay for diabetic patients.

Program outcome measures are reported on a regular basis to the hospital's Performance Improvement Committee. To date, the inpatient glycemic control program has demonstrated significant improvements in glucose control outcomes. There has been a 40% reduction in patients who averaged blood glucose >180 mg/dL throughout the admission and a 38% reduction in inpatient hospital days with patient blood glucose >300 mg/dL. Despite these improvements with hyperglycemia, the hypoglycemia rate has remained extremely low. According to 4th quarter 2012 data, there was only 1%-2% of total inpatient days with hypoglycemia which has resulted in almost a one-day decrease in the length of stay for patients placed on the standardized insulin protocol.

The inpatient glycemic control team meets on a monthly basis to discuss performance measures, concerns, areas for improvement, and action plans following the FMEA process. During program implementation, strong focus has been placed on educating staff. Two weeks prior to each unit roll-out, extensive training is conducted, including didactic background and introductory sessions on the new program targeted to nurses, physicians, and residents. Updated procedures are also reviewed among pharmacy staff. This education is followed by hands-on practice sessions that include previews of new clinician order sets. Hands-on assistance is also provided to staff during the immediate program launch.

Program implementation to the remaining medical-surgical inpatient units is expected to occur over the next three months. Sustaining improved glycemic control involves a continuous process of staff training and education, data collection, analysis of performance measures, and reassessment of quality indicators. One of the key lessons learned is the importance of clinicians reaching agreement on glycemic targets and principles of insulin use. The appropriate culture must be present to prioritize and standardize glycemic control. Improved communication between staff and providers also contributes to the success of the project. In addition, it is also critical to identify a "champion" for each nursing unit who can proactively address questions and concerns. Staff education to reinforce achievement of program goals is similarly important. Sufficient time for program planning and implementation should also be provided. It should be noted that both the clinical treatment protocols and the staff education module are available to be shared with other organizations.

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

Category 2: Expand Chronic Care Management Models

Process Milestone: Improve the percentage of diabetic patients who select a self-management goal by 20% over baseline.

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	306.00
Denominator (if absolute number, enter "1")	*	1,506.00
Achievement		20.3%
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

This milestone, which pertains to diabetic patients seen in the Family Care Clinic, was achieved by September 2011 as evidenced by the registry's patient summary data report. Baseline data, which was established in July 2010, indicated that the percentage of diabetic patients who had selected a self-management goal was 10%. As of 9/30/11, this percentage had increased to 20%.

One of the challenges to increasing this percentage relates to the patient's compliance in keeping their clinic appointments. Those patients who are engaged in their care are more likely to adopt a self-management goal to improve their health in comparison to patients who do not show up for their clinic visits. In addition, there may be incomplete documentation on whether a patient has selected a goal and the actual number may be somewhat higher than what the data indicate. The registry's data field currently lists a "yes/no" response for the self-management goal selection. It is unclear whether the patien has declined to select a goal, they were not asked, or the information was not captured on the clinic note. To address this issue, the clinic note template will be modified to ensure self-management goal information is captured. In addition, during the clinic visit, staff will obtain direct feedback from the patient as to why they selected a self-management goal to see if their response could assist other patients in selecting a goal. If the patient has declined to choose a goal, staff will try to determine the barrier(s) which may be preventing the patient from selecting one and then work with the patient to overcome the barrier(s).

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone	*	12%
Achievement Value		1.00

Process Milestone: Expand the number of telephone interactions between diabetic patients and the health care team by an additional 150 calls.

(insert milestone)

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

This milestone was achieved by December 2011. A total of 161 calls were made to diabetic patients between July - December 2011, as documented by a telephone log used by the Diabetes Management Clinic staff that lists the calls made to patients and the reason for the calls. These telephone interactions represent a transition from the traditional way of providing care through a clinic visit to a "virtual visit." They can be accomplished in two ways: 1) by clinic staff, including nurses, physicians, and/or pharmacists proactively contacting patients and 2) by staff responding to patients who contact the clinic with questions. This visit can occur for various reasons, including explaining to a patient why their medication is being adjusted; providing information on lab test results; or coaching a patient on a self-management goal. Clinic staff has received positive feedback from patients who have participated in this virtual visit.

Improvements have been made in how the telephone interactions are documented. When the pilot program was launched in late 2010, the telephone log was tracked on paper. A short time later, staff automated the log by building an Access database to track this information. More recently, with the implementation of the NextGen electronic health record, these telephone interactions are being electronically tracked as a virtual encounter in the medical record. It is also more efficient for staff because they can check the patient's chart electronically while conducting the virtual visit rather than delaying the telephone interaction until the paper chart has been retrieved. This program is a good initial model to demonstrate a mechanism for actualizing the shift from a "visit volume" focus to a "value" focus.

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: Riverside County Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * Yes

Category 2: Redesign Primary Care

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

Redesign Primary Care

DY Total Computable Incentive Amount: * $ 4,823,100.00

Incentive Funding Already Received in DY: * $0.00

Process Milestone: Train 70% of relevant staff in the Family Care Clinic on methods for redesigning the clinic to improve efficiency.
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here) * 66.00

Denominator (if absolute number, enter "1") * 94.00

Achievement 70.2%

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

This milestone was achieved as of March 2012, as documented by the Family Care Clinic Wellness Meeting agenda, training materials, and staff sign-in sheets. Training was conducted for the nursing and non-nursing staff, residents, attending physicians, and other clinicians who are actively involved in patient flow processes in the clinic. The session was conducted by the Family Care Clinic's physician and nursing leadership in support of the clinic's goal to become a patient-centered medical home.

Discussion topics focused on the Family Care Clinic Flow Model which outlines all of the steps and processes pertaining to a clinic visit, from the time when the patient calls to make an appointment through to the conclusion of the clinic visit. Goals include decreasing clinic cycle times, ensuring diagnostic test and lab results are available at the time of the visit, including patients in their plan of care, improving chart availability, and ensuring patient follow up appointments are made. Procedures were reviewed for each step of the process to ensure all staff, including clinic schedulers, registration staff, and the patient care team, know their role/responsibilities and how they contribute to the efficient flow of the clinic. Hand-out materials outlining the flow model were distributed to all participants. It included information clinic schedulers should obtain from the patient when making an appointment and how registration staff contact patients to remind them of their appointments. In addition, the procedures followed by medical unit clerks, registration staff, and patient care team members from the time the patient arrives for the appointment through to the conclusion of the clinic visit was discussed. Included in the review was the process for physician/patient care team huddles that occur on the day of the visit before the morning and afternoon clinic sessions. During this meeting, staff questions and concerns about specific steps in the patient flow model were addressed.

Clinic management will reinforce this training by tracking various throughput measures, including cycle time, clinic start times in the morning and afternoon, patient no-show rates, and third next available appointment. Results of these measures as well as other metrics pertaining to clinic operations are reported to the Family Care Clinic staff on a regular basis at their monthly Wellness staff meetings. Training on the patient flow model is also a component of the clinic's new employee orientation. Nursing staff and residents, spend a portion of their orientation learning clinic operations through direct experience, e.g., which includes sitting at the front desk where patients check in, etc. New attending physicians receive similar training on clinic operations.

In a letter dated August 10, 2012 from the Department of Health Care Services to RCRMC, a question was raised on whether we were aware of any literature references that demonstrate the effectiveness of this training on changing and sustaining clinician and staff behavior. Our research has not been able to identify literature specific to this training. However, we did identify a process improvement sustainability model, developed by the NHS Institute for Innovation and Improvement in the United Kingdom, which points out that staff involvement and training are necessary to sustain change. Other key factors include: fit with goals and culture; clinical and senior leader engagement in change; credibility of evidence; adaptability of improved process that supports continuous improvement; monitoring progress and communication of results; infrastructure for sustainability, including staff, facilities and equipment; and staff attitudes towards sustaining change, including empowerment. More information on this model can be found at the following

DY Target (from the DPH system plan) or enter "yes" if "yes/no" type of milestone * 70%

Achievement Value 1.00

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Riverside County Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * Yes

Category 2: Redesign to Improve Patient Experience

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

DY Total Computable Incentive Amount: * $ 4,823,100.00

Incentive Funding Already Received in DY: * $ 1,607,700.00

Process Milestone: Establish a steering committee comprised of organizational leaders, employees, and patients/families to oversee improvements in patient and/or employee experience in the Family Care Clinic.
(insert milestone)

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

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

This milestone was achieved in September 2011 as evidenced by Patient Experience Committee minutes. Due to the importance of the patient experience initiative, the Steering Committee has broadened its focus from the Family Care Clinic to the entire organization. Its membership includes senior hospital administrators, physicians, quality management staff, the hospital's patient advocate, and nursing staff. Committee members are also discussing how to incorporate direct patient involvement in the patient experience initiative, such as through focus groups or other mechanisms.

The committee will oversee the full roll-out of the hospital's patient experience initiative, referred to as "ICARE" (Introduce yourself, Connect/Courtesy, Attentive/Acknowledge, Responsive/Responsibility; and Engage/Educate). Multiple strategies have been identified to communicate the importance of this initiative to all hospital staff and how they contribute to enhancing the patient's experience with RCRMC services. As noted in another milestone, training is being implemented to educate employees about the program's goals and objectives. Posters will be placed throughout the hospital, reinforcing the principles of the ICARE program. A patient experience newsletter is under development. The employee performance evaluation is being re-evaluated to determine what changes may be needed to hold staff more accountable for increasing patient satisfaction. Patient experience champions will be identified for each department. Quarterly rallies will be held with hospital employees during all shifts to share important information, including results from the CG-CAHPS and HCAHPS surveys which will help measure the success of the patient experience interventions. These survey results are also monitored at the hospital's Performance Improvement Committee.

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 plan to roll out a regular inquiry into patient experience in the Family Care Clinic.

(insert milestone)

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

This milestone was achieved in June 2012. A Family Care Clinic patient experience plan, which included the pilot of a survey tool to assess patient satisfaction with clinic services, was approved by the Ambulatory Care Committee, as documented by the committee's June 2012 minutes. The plan was also presented for discussion at the May 2012 meeting of the Patient Experience Steering Committee.

The CG-CAHPS survey, which was implemented in late 2012, is administered based on a random sample of all patients seen in RCRMC's three adult primary care clinics. Survey results are statistically significant at the system-wide rather than individual clinic level. Family Care Clinic management wanted to use a survey tool that could provide more direct feedback on the patient's experience and identify areas for improvement specific to the clinic.

The clinic management team worked together to develop the written survey tool. It will ask patients to assess the clinic in five key areas: communication with non-physician staff and providers, respect, efficiency, attentiveness, patient involvement in the care planning process, and overall clinic experience. Surveys will be available in both English and Spanish.

In the second quarter of 2012, the survey instrument was tested to evaluate the administration process and the clarity of the survey instrument questions. Initially, patients were handed the survey in the waiting room and asked to complete it at the conclusion of their clinic visit. This practice resulted in a low response rate. The administration process was changed. Patients received the survey as they entered the exam room. At the end of their clinic visit, they were asked to place their completed survey in a drop box in the clinic. This change in practice resulted in a higher number of surveys being completed. The pilot also revealed that some of the questions were not well understood by patients, resulting in these milestones being modified.

This revised survey has been implemented. Results will be manually compiled and entered into a database for analysis. Quarterly survey results will be discussed at the Family Care Clinic Wellness staff meeting where identified patient issues and concerns can be discussed and ideas for process improvement can be exchanged. In addition, positive patient feedback and employee performance which support the patient experience program will be acknowledged. Survey results will also be discussed at the Ambulatory Care Committee on a regular basis.

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: Train 50% of Family Care Clinic staff on patient experience program goals and objectives.

(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	59.00
Denominator (if absolute number, enter "1")	*	107.00
Achievement		55.1%
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

This milestone was achieved in April 2012 as evidenced by the meeting agenda, staff sign-in sheets, PowerPoint presentation, and post-tests. Although this milestone specifically pertains to the Family Care Clinic, this training will be implemented hospital-wide as part of RCRMC's patient experience initiative. Training was conducted by the hospital's Patient Experience champion at the Family Care Clinic's Wellness staff meeting. Participants included nursing and non-nursing staff, residents, attending physicians and mobile health clinic staff. Topics presented included: definition of the term "patient experience;" overview of RCRMC's patient experience initiative, "ICARE:" Introduce yourself, Connect/Courtesy, Attentive/Acknowledge, Responsive/Responsibility; and Engage/Educate; program's goals and objectives; and examples of employee actions which reinforce these concepts.

Clinic staff training will be reinforced through a number of different strategies. There will be a series of educational sessions for all staff that will highlight different aspects of improving patient experience. Performance evaluations will be modified as necessary to hold staff accountable for improving patient satisfaction. It will also be reinforced through hospital-wide strategies, such as a patient experience newsletter and quarterly employee rallies where CG-CAHPS and HCAHPS survey results will be presented and areas for improvement discussed and successes shared.

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: Riverside County Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

REPORTING ON THIS PROJECT: * Yes

Category 2: Increase Specialty Care Access/Redesign Referral Process

Below is the data reported for the DPH system.

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

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Increase Specialty Care Access/Redesign Referral Process

DY Total Computable Incentive Amount: * $ 4,823,100.00

Incentive Funding Already Received in DY: * $0.00

Process Milestone: Create a plan to redesign the specialty referral process that will address: 1) development of standardized criteria; 2) preliminary work-up/assessment guidelines, and 3) prioritization of specialty care referrals.
(insert milestone)

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

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

This milestone was achieved by June 2012, as documented by the revised Specialty Clinic Referral Process Policy and the RCRMC Medical Referral Guidelines document which were approved by the Medical Executive Committee. A team comprised of RCRMC's medical director, an assistant hospital administrator, director of the Provider Relations Department, and the hospital's compliance officer worked together to create a plan to redesign the hospital's specialty referral process. The Provider Relations Department, which processes the referrals, handles over 3,500 requests a month through a paper/fax system. A relatively low percentage of referrals are approved due to various factors, including the referral request was not accompanied by the appropriate work-up documentation or the documentation did not support the referral request according to evidence-based clinical decision support criteria.

In revising the hospital's referral policy, the project team focused their efforts on establishing more standardized referral guidelines so patients meet common criteria to justify the need for the referral, requiring that designated tests and other necessary pre-visit work-ups be performed before the visit is scheduled, and prioritizing referrals to ensure that more urgent requests were expedited. In developing the referral guidelines, referral patterns to the specialty clinics were analyzed to identify the most common diagnoses. RCRMC's medical director contacted all of the physician department chairs to assist in the drafting of referral guidelines for the specialties in their respective areas. Information in the referral guidelines included: referral criteria by diagnosis; primary care management guidelines which the referring physician should follow before initiating the referral; diagnostic tests that should be completed before the referral request is submitted to decrease the number of unnecessary visits to the specialist; and symptoms by diagnosis that would prioritize the urgency of the referral. The referral guidelines were submitted for comments to primary care physician leaders and final modifications were made.

As noted above, the Medical Executive Committee approved the revised specialty referral policy and medical referral guidelines and they have been implemented.

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

Category 2: Increase Specialty Care Access/Redesign Referral Process

Process Milestone: Train 50 staff in Riverside County-based primary and specialty clinics, plus staff in referring clinics regarding new referral guidelines.

(insert milestone)

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

This milestone was achieved by June 2012, as evidenced by presentation materials and staff sign-in sheets. Meetings were held in April and May 2012 to inform Riverside County staff about the new Specialty Clinic Referral Process Policy and the Medical Referral Guidelines document. A total of 84 staff from RCRMC's primary and specialty clinics, scheduling, and patient accounts staff participated. In addition, nursing personnel from Riverside County's family health centers attended.

Topics presented included the reasons why the referral policy was being revised and the new specialty clinic referral criteria. Examples of the new medical referral guidelines, pertaining to general surgery and orthopedic surgery, were discussed. Other key information presented included the recent change of placing provider relations staff in high volume clinics, such as the Family Care Clinic and the Surgery/Orthopedic clinics, to facilitate the efficient processing of appropriate referrals. The importance of completing pre-visit work-ups prior to requesting a referral was also stressed. In addition, staff was instructed on the proper completion of the referral request form.

Nurse champions, who have been identified in key clinics, will be responsible for coordinating the referral process in their respective areas, including reinforcing staff training. In addition, specialty care referral guidelines have been placed on the RCRMC Intranet for easy staff access. Planning is underway to make the evidence-based clinical decision criteria (e.g., InterQual) available on the intranet to all physicians and nursing staff involved in the referral process. Until web access is available, clinic staff has received copies of referral criteria for the most common procedures for each specialty clinic.

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

Category 2: Increase Specialty Care Access/Redesign Referral Process

Process Milestone: Educate 50 referring primary care physicians on the new referral guidelines.

(insert milestone)

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

This milestone was achieved by June 2012, as evidenced by the Confirmation of Education on Referral Guidelines certificates issued by RCRMC's Department of Education. A total of 58 referring physicians from RCRMC's primary and specialty clinics and referring physicians from the county's family health centers completed the online training course which was offered on the hospital's intranet website that is coordinated by the hospital's Department of Education. Upon their review of the guidelines, physicians received a training certificate. The medical referral guidelines remain on the website so primary care physicians can access them as a reference tool.

This training will be reinforced in several ways. A physician advisory group comprised of primary care physicians and specialists has been established to discuss the referral management guidelines. They will meet monthly starting in October to address questions or concerns and identify any suggested changes. In addition, specialists will begin attending primary care physician meetings to educate them on the referral guidelines pertaining to their specialty and to facilitate open discussion regarding their usage.

Two senior primary care physicians and one senior specialty care physician also review referrals from all Riverside County-affiliated primary care physicians on a weekly basis. They provide immediate feedback to the referring physicians when there are potential inappropriate referrals, insufficient documention, or an opportunity to improve the referral process. The utilization management supervisor is also available to provide individualized assistance to referring physicians as needed.

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: Riverside County Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

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:	*	$ 4,182,750.00
Incentive Funding Already Received in DY:	*	$ 4,182,750.00

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

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

This milestone was achieved in July 2011, as evidenced by RCRMC's contract with The Jackson Group which was amended to incorporate the use of the CG-CAHPS survey. This survey which was officially implemented in October 2011, is available in English and Spanish. It is administered on a continuous basis using a telephone survey methodology. A random sample of patients who were seen in one of RCRMC's three adult primary care clinics are contacted each month, with a target number of 100 survey responses received per quarter, or 400 responses per year. Survey results, which are available on a quarterly basis, are compiled at the system rather than clinic level. They are presented for discussion at the Ambulatory Care Committee and the Patient Experience Steering Committee.

As part of a new patient experience initiative, plans are being developed to disseminate the results of the CG-CAHPS and HCAHPS surveys to hospital staff in several ways. Quarterly rallies for all hospital staff are being scheduled to promote the goals of the patient experience initiative. Survey results will be shared and the role which each employee plays in increasing patient satisfaction with hospital services will be discussed. In addition, managers will discuss the survey results with their staff on a regular basis at their departmental meetings and identify process improvement opportunities.

CG-CAHPS survey results will become part of DSRIP reporting in DY 8. Preliminary findings suggest that clinic access, including getting timely appointments, care and information, is an area where process improvement is needed. Clinic management staff are reviewing these results and will be developing action plans to address these issues.

Achievement	Yes
Achievement Value	1.00

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Riverside County Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

Category 3: Care Coordination *(required)*

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

Care Coordination (required)

DY Total Computable Incentive Amount:	*	$ 4,182,750.00
Incentive Funding Already Received in DY:	*	$ 2,091,375.00

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

Data Collection Source	*	Data warehouse
Numerator	*	37.0
Denominator	*	1,954.0
Rate		1.9

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):

Data for this measure pertain to diabetic patients 18-75 years of age seen in the Family Care Clinic and Internal Medicine Clinic who were hospitalized with a principal diagnosis of short-term complications of diabetes, such as ketoacidosis, hypersmolarity, or coma. Data in this report are for the July 1, 2011-June 30, 2012 time period.

In the March 2012 report, representing the July–December 2011 time period, the following data was listed for this measure: Numerator: 15; Denominator: 1,954

As the data indicate, the number of diabetic patients hospitalized with short-term complications of diabetes has remained very low (<0.01%) within the past 12 months. This result is due to the implementation of the hospital-wide glycemic control initiatives, including inpatient, ambulatory (including Diabetes Management Clinic and pharmacy-driven titration program), and peri-operative glycemic control projects, which have helped improve diabetes control across the continuum of care at RCRMC. With improved coordination of care from the inpatient, peri-operative, and outpatient care settings, patients are better able to obtain more timely and effective follow-up care that can reduce hospitalizations for short-term complications.

In addition, with the recent changes to the diabetes registry (technical configuration and updating of information), the diabetes care teams will be better able to aggressively target the patients at highest risk for diabetes complications. These patients receive more frequent clinic and phone visits to address and manage potential barriers to improving glycemic control. The registry also helps diabetic patients receive timely treatment and preventive care that has been shown to significantly lower diabetic complications.

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	*	Data warehouse
Numerator	*	28.0
Denominator	*	1,954.0
Rate		1.4

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):

Data for this measure pertain to diabetic patients 18-75 years of age seen in the Family Care Clinic and Internal Medicine Clinic who were hospitalized with severe uncontrolled diabetes as a principal diagnosis. This report reflects data between July 1, 2011–June 30, 2012.

In the March 2012 report the following information was listed for this measure for the time period of July-December 2011: Numerator: 145; Denominator: 1,954

The numerator for the first six months of the year was significantly higher than the numerator for the entire year. Upon further staff review, it was determined that the data query for the first six months was incorrectly produced. Rather than running the report using the designated ICD-9 codes as principal diagnosis only, the query included all patients who had the designated codes as principal or secondary diagnosis. The corrected numerator for this time period is 14. Data for the current report was re-verified to ensure it meets the numerator definition for this measure.

The number of diabetic patients hospitalized with severe uncontrolled diabetes has remained relatively low over the past 12 months. This result can be attributed to the continuum of diabetes management services offered at RCRMC as described in this report.

Achievement	Yes
Achievement Value	1.00

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP
DPH SYSTEM: Riverside County Regional Medical Cente
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

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 (*).*

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Preventive Health (required)

DY Total Computable Incentive Amount:	*	$ 4,182,750.00
Incentive Funding Already Received in DY:	*	$ 2,091,375.00

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

Data Collection Source	*	Data warehouse
Numerator	*	2,111.0
Denominator	*	3,555.0
Rate		59.4

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):

Data for this measure pertain to the time period of July 1, 2011 – June 30, 2012. In the March report, the following information was reported for the July-December 2011 timeframe: Numerator: 1,474; Denominator: 3,555

The mammogram screening data pertain to women seen in the Family Medicine Clinic, Internal Medicine Clinic, or the Women's Health Clinic. To increase the number of women who receive regular mammograms, RCRMC continues to offer the "Every Women Counts" breast cancer screening program which is sponsored by the California Department of Public Health. In addition, the Radiology Department sends letters to patients and their primary care physician to remind them that it is time for the patient to have an exam. It also specifies the type of exam the patient should receive, e.g., annual mammogram, six-month follow up, additional evaluation view, or biopsy.

In the Family Care Clinic there is also a section on the clinic note which prompts the physician to check whether the patient is due to receive certain preventive interventions, such as the annual mammogram, flu vaccine, or other immunizations. Family medicine physicians are also educated on breast screening guidelines.

Despite these efforts, certain barriers continue to impact the number of women who receive mammograms such as lack of patient transportation to appointments, cultural issues, or the lack of reliable contact information to follow up with the patient to schedule the screening.

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	*	Manually (sample)
Numerator	*	1,418.0
Denominator	*	5,620.0
Rate		25.2

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):

Data for this measure pertain to September 2011-February 2012. In the March report, data for the time period of September-December 2011 was included: Numerator: 697; Denominator: 5,620.

The list of patients 50 years of age and older who received influenza immunizations was manually produced by the pharmacy department which coordinates the flu immunization program. This list represents all patients meeting the DSRIP criteria who received the flu shot, not just a sample. The denominator was identified using a data warehouse. The data listed here reflect the flu shots administered to inpatients, plus outpatients seen in RCRMC's Family Care Clinic. It includes only those patients who received flu shots at RCRMC. Patients who received flu immunizations at another provider are not reflected in this information because verification of immunization has been difficult to obtain. The data also reflect patients who refused flu shots. While over 80% of eligible patients are screened, the percentage of patients receiving the flu immunization is significantly less because many patients are already immunized or they refuse the vaccine.

During the past six months, several initiatives have been implemented that will positively impact data collection and reporting for this measure in the future. The hospital is transitioning to the electronic health record in both inpatient and outpatient areas. In the Family Care Clinic, the NextGen system will track whether a patient receives immunizations, including the flu vaccine, at RCRMC or through another provider. Hospital inpatient units recently started completing all documentation online which will lead to easier data extraction and more accurate information. The pharmacy department is also now able to generate reports from the automated dispensing cabinets and order entry software.

During this flu season, the vaccine administration is being expanded to other primary care clinics, including Internal Medicine and Women's Health. Education materials and flyers from the Centers for Disease Control will also be used to create awareness among patients and staff about the importance of getting a flu vaccine.

Achievement	Yes
Achievement Value	1.00

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Riverside County Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

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).*

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At-Risk Populations (required)

DY Total Computable Incentive Amount:	*	$ 4,182,750.00
Incentive Funding Already Received in DY:	*	$ 2,091,375.00

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

Data Collection Source	*	Registry
Numerator	*	257.0
Denominator	*	1,954.0
Rate		13.2

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):

Data for this measure, for the time period of July 1, 2011–June 30, 2012, pertain to diabetes patients treated in RCRMC's two primary clinics: Family Care Clinic and Internal Medicine Clinic. The data source to identify the numerator is a registry while the data source for the denominator is a data warehouse. In the March 2012 report, data for the July-December 2011 time period was included: Numerator: 296; Denominator: 1,954.

This report indicates a decline in the numerator from 296 to 257 which may not be consistent with current patient experience. A contributing factor to this reduction is that a major staff effort is underway to update the registry information. There has been steady growth in the number of diabetic patients treated in these primary clinics. However, because it is a manual entry registry, it has been a significant challenge for staff to maintain the currency of the information. This registry updating process involves entering clinic visit data, lab test results, and other information on existing patients as well as new patients. Patients who are no longer seen at RCRMC have been placed in an inactive file. Because all supporting lab data may not have yet been entered in the registry, the actual number of patients who have their cholesterol under control may be somewhat higher than what these data suggest.

This update process should result in more accurate, complete data in future reporting periods. In addition, RCRMC plans to purchase the i2iTracks Population Health Management System along with expediting implementation of the NextGen electronic health record in the Internal Medicine Clinic over the next few months. The NextGen system is already operational in the Family Care Clinic. These initiatives will also contribute to greater data accuracy and consistency in the future.

In addition to attempts to report accurate and complete data from the registry, diabetes care providers in the Family Care and Internal Medicine Clinics are making efforts to ensure all diabetic patients receive cholesterol-lowering therapy based on current guidelines. Patients are closely tracked with lab data and followed up in the clinic until the patient achieves the target goal of LDL <100 mg/dL. The pharmacy-driven diabetes medication titration program and Diabetes Management Clinic also track LDL levels and recommend adjustments to medication therapy if the patient has not achieved the LDL goal. LDL management is included as part of their routine care regimen. This multidisciplinary care will help more patients obtain their LDL goal.

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	*	Registry
Numerator	*	382.0
Denominator	*	1,954.0
Rate		19.5

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

Data for this measure, for the time period of July 1, 2011–June 30, 2012, pertain to diabetes patients treated in RCRMC's two primary clinics: Family Care Clinic and Internal Medicine Clinic. The data source to identify the numerator is a registry while the data source for the denominator is a data warehouse. In the March 2012 report, data for the July-December 2011 time period had been reported on diabetic patients with HbA1c <9% (Numerator: 441 and Denominator: 1,954.) However, after the report was submitted, CMS/State officials determined that the measure should be changed to HbA1c <8%. The information in this report reflects this change in the measure.

As mentioned under the previous milestone, a major staff effort is underway to update the information captured in the registry. Because the registry depends on manual data entry, all HbA1c lab results are not yet reflected in the database. Therefore, the information being reported may be understated.

As mentioned previously, RCRMC has developed and implemented several diabetes management services to address patient glycemic control. They include the Diabetes Management Clinic, which is comprised of a nurse practitioner, nurses, nutritionist, diabetes educator, health service assistants, and pharmacists, as well as the pharmacy-driven diabetes medication titration service. Each of these programs provides concurrent diabetic care along with the primary care physicians from the Family Medicine and Internal Medicine Clinics. Patients are able to receive more individualized, diabetes-specific care, and patients are able to benefit from more frequent clinic and phone visits. As patients receive more intensive education and provider support from these services, it is expected they will have a positive impact on this measure which should be reflected in future reports.

Achievement	Yes
Achievement Value	1.00

DSRIP Semi-Annual Reporting Form

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

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

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

DY Total Computable Incentive Amount:	*	$ 2,359,500.00
Incentive Funding Already Received in DY:	*	$ 1,179,750.00

Compliance with Sepsis Resuscitation bundle (%)

Numerator	*	13
Denominator	*	58
% Compliance		22.4%

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):

This milestone was fully achieved by June 2012. The compliance rate in this report is based on July 2011-June 2012 data. A sepsis resuscitation bundle compliance rate of 23.5% for the time period of July-December 2011, was included in the March 2012 report.

While RCRMC's compliance is relatively low, it should be pointed out that the compliance rate is based on the number of patients whose care was 100% compliant with all elements of the sepsis resuscitation bundle. One fall-out with a bundle element will result in a status of non-compliance even though the patient may still have received care according to the other bundle elements. In addition, there is the challenge of proactively identifying patients who have sepsis. Such patients are identified when hospital staff contacts the Rapid Response Team (RRT) to assess a patient whose medical condition is deteriorating. If the patient meets criteria, the sepsis resuscitation bundle is initiated. Extensive staff education, as described below, is occurring to increase hospital staff knowledge of the early signs of sepsis and the role of the RRT in caring for sepsis patients.

Two problems have been identified with selected elements of the sepsis resuscitation and/or management bundles, including: 1) reducing the median time (≤ 60 minutes) for the Rapid Response Team to begin infusing the first antibiotic after the patient meets sepsis criteria and 2) maintaining blood glucose values with a median level of <150 mg/dL from hour 6-24. The antibiotic information was gathered from the medication administration record to assess the time at which the antibiotics were administered. The blood glucose information was obtained from the laboratory dashboard in the electronic health record.

To address these issues and increase hospital staff awareness about the importance of early sepsis detection and management, an intensive staff education effort was undertaken in early 2012. The sepsis protocols nurse has been providing continuous education to all nurses, certified nursing assistants and health services assistants in the Emergency Department, critical care areas, and other inpatient units. This training is also provided to new employees and travel/registry staff. Discussion topics include:

• definition of sepsis and the signs/symptoms of early sepsis;

• importance of administering antibiotics within 60 minutes or less of sepsis recognition;

• maintaining glucose control <150 mg/dL through Accu-checks every six hours; and

• role of the RRT, including when the team should be called.

As of September 2012, over 650 staff have been trained. According to 4th quarter 2011 data, the median minutes to antibiotic administration was 139 and glucose maintenance at the median of <150 mg/dL was 75%. The 1st quarter 2012 results, which occurred after staff training was initiated, indicated that the antibiotic administration time had decreased to 47 minutes and glucose maintenance had dropped to 70%. The sepsis protocols nurse is continuing to conduct continuous training sessions every week so that these outcome measures can be improved.

Another process improvement that is being implemented is the purchase of point of care blood lactate testing devices to facilitate the earlier identification and management of sepsis. Five meters have been purchased to be used in the Emergency Department, adult critical care unit, neonatal intensive care unit, and by the RRT. Staff training is set to begin in mid-September with the go-live date scheduled for mid-October.

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

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

Optional Milestone: Participate in the HASC Southern California Patient Safety Collaborative to share data and practices witih other hospitals.

(insert milestone)

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

This milestone was achieved in February 2012. The critical care clinical pharmacist who manages data collection for the sepsis program conducted a presentation on RCRMC's "Pharmacist-Driven Sepsis Program" at the 2/7/12 meeting of the Southern California Patient Safety Collaborative. This collaborative is affiliated with the Hospital Association of Southern California (HASC), a trade association which represents 180 hospitals in a six-county region of Southern California. The completion of this milestone is documented by the meeting agenda and PowerPoint presentation.

The presentation included such topics as: challenges associated with defining and diagnosing sepsis, including the relationship between systemic inflammatory response syndrome, sepsis, severe sepsis, and septic shock; importance of the rapid diagnosis and management of sepsis; early sepsis management interventions implemented at RCRMC, including creation of a sepsis order form and designating physician champions; overview of the pharmacist-driven sepsis program, including how the identification of patients with sepsis is facilitated through the hospital's Rapid Response Team (RRT); training requirements for the clinical pharmacist; and the creation of a sepsis/RRT book used by RRT members which includes sample sheets to find oxygenation parameters; sepsis policy and guidelines; renal dosing guidelines; advanced cardiac life (ACLS) support algorithms; vasopressor information; daily workflow guide; and other useful forms.

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 six months of data collection on the 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)	*	N/A
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

This milestone was achieved by December 2011. Originally, baseline data for the six-month time period between February–July 2011, were submitted to SNI, as documented by: 1) a spreadsheet listing the baseline data and 2) SNI staff's acknowledgement of the data receipt. After this information was submitted, the State and CMS clarified that the baseline data should pertain to a 12-month period. RCRMC resubmitted baseline data to SNI for February-December 2011 data. The time period is only 11 months because the current sepsis management program was implemented in February 2011. The compliance rate was 23.8%, based on a numerator of 21 and a denominator of 88.

Patients with severe sepsis or septic shock are identified when nurses call the Rapid Response Team (RRT) to assess a patient in critical condition. The denominator includes all patients who were identified by the RRT as having sepsis and the numerator is the number of patients whose care complied with all elements of the sepsis resuscitation bundle.

The sepsis resuscitation bundle data collection methodology is managed by a critical care clinical pharmacist who is a member of the RRT. Most data elements of the bundle are collected at the patient's bedside in real-time or from the laboratory dashboard in the electronic medical record, including antibiotic administration time, lactate levels, etc. The pharmacist completes a form with this information. Data that cannot be obtained from these sources are abstracted from the patient's medical record.

A process improvement pertaining to sepsis data collection is being implemented. An Access database is being built to capture all data related to sepsis data collection. This information will be entered in real-time by the pharmacist each day. Queries will be set up to allow for easy data abstraction. Each data element which falls out of compliance with the sepsis bundle will be documented in real-time to identify systematic and immediate improvement. The new data system should be completed in the Fall 2012.

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: Riverside County Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

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 (*).*
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Central Line Associated Blood Stream Infection

DY Total Computable Incentive Amount:	*	$ 2,359,500.00
Incentive Funding Already Received in DY:	*	$ 1,769,625.00

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

Numerator	*	657.00
Denominator	*	662.00
% Compliance		99.24%

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):

Please note that, in the March 2012 report, the Central Line Insertion Practices (CLIP) compliance rate and the Central Line Bloodstream Infection (CLABSI) rate, were both reported under a different milestone entitled "Report CLIP and CLABSI results to the State." For this report, the information has been included here.

This milestone has been fully achieved as of June 2012. The CLIP compliance rate for the time period of July 2011–June 2012 is shown above. This rate is pertains to patients with central lines in all of RCRMC's intensive care units, including the adult, pediatric, and neonatal intensive care units, for whom all elements of the CLIP bundle are documented. In comparison to baseline data, RCRMC has sustained a high compliance rate.

For the same time period, the CLABSI rate for all critical care areas and other inpatient units is 0.65 per 1,000 catheter days based on a numerator of 12 and a denominator of 18,507. In comparison to baseline data, there has been a significant decrease in the CLABSI rate per 1,000 catheter days.

In the March 2012 report the following data pertaining to the time period of July–December 2011 was provided: The CLIP compliance rate was 99.4% (312/314) and the CLABSI rate was 0.76 per 1,000 catheter days (7/9,270).

RCRMC's challenge will be to sustain its high compliance rate with the CLIP bundle. Interventions include a strong education program targeted to residents, nurses, and members of the peripherally inserted central catheter (PICC) team. The Infection Prevention and Control staff conducts training on the CLIP bundle elements, including using chlorhexidine to prepare the patient's skin prior to insertion of the central line, use of good hand hygiene, and wearing a mask during the procedure. Hospital staff are instructed to use a checklist that lists all of the CLIP bundle elements for every patient who receives a central line. These forms are sent to the Infection Prevention and Control Department for review. In addition, hospital staff are required to report all insertion failures to Infection Prevention and Control as a quality improvement initiative and to provide information for future CLIP training sessions.

The CLABSI rate has significantly decreased due to RCRMC's use of a bundle developed by John Hopkins University. These elements include, but are not limited to: daily review of line necessity; IV tubing is changed every Thursday per protocol; dressing is intact; dressing changed within seven days; and unused lumens have clave device. Regarding the review of central line necessity, infection prevention and control staff perform random chart audits to check for evidence that physicians have completed this review. In the fall of 2011, the RCRMC Medical Director began sending letters to physicians who were not in compliance with this practice, advising them of the requirement. At the same time, physicians who were in compliance were acknowledged by letter. Compliance with review of central line necessity has increased as a result. In addition, there is a new device being tested on two nursing units which automatically disinfects the port. It attaches to the central line port and has an alcohol pad in it. To date, there has been a CLABSI rate reduction of 49.8% and 13.1%, respectively, on these units.

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: Report at least six months of data collection on the CLIP 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)	*	N/A
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

This milestone was achieved as of December 2011. Originally, baseline data were originally submitted to SNI in December 2011 for both Central Line Insertion Practices (CLIP) and Central Line Bloodstream Infection (CLABSI) for the six month time period of July–December 2009. This submission was documented by: 1) spreadsheet listing the baseline data and 2) SNI staff's acknowledgement of the data receipt. After the March 2012 DSRIP report was submitted, the State/CMS clarified that the baseline data should be based on a 12-month period. RCRMC re-submitted its CLIP and CLABSI baseline data to SNI for the time period of July 2009–June 2010.

CLIP: The revised numerator, which pertain to the number of patients with central lines in all of RCRMC's intensive care units, including the adult, pediatric, and neonatal intensive care units for whom all elements of CLIP are documented, is 588. The revised denominator, which pertains to the total number of patients with central lines occurring in RCRMC's adult, pediatric, and neonatal intensive care units is 590, with compliance at 99.66%.

CLABSI: The revised numerator is 56, representing the number of laboratory-confirmed primary bloodstream infections occurring in patients located in critical care units or other inpatient units who had a central line in place at the time of, or within 48 hours before, the onset of infection. The revised denominator is 17,455, representing the number of device days. The CLABSI rate is 3.21 per 1,000 catheter days.

Surveillance for CLIP and CLABSI are performed by using the Center for Disease Control (CDC) Definitions and the 2009 Patient Safety Component Protocol from the National Healthcare Safety Network (NHSN) at the CDC. Data are collected by infection prevention and control personnel and results are reviewed by the Infection Prevention and Control Committee. Case finding is accomplished through one or more of the following methods: laboratory findings, chart review, staff Interviews, RCRMC rounds, computer information systems, and/or patient interview.

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

DSRIP Semi-Annual Reporting Form

CA 1115 Waiver - Delivery System Reform Incentive Payments (DSRIP)
DPH SYSTEM: Riverside County Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

Category 4: Surgical Site Infection Prevention

REPORTING ON THIS PROJECT: * Yes

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

Surgical Site Infection Prevention

DY Total Computable Incentive Amount:	*	$ 2,359,500.00
Incentive Funding Already Received in DY:	*	$ 1,769,625.00

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

Numerator	*	22.00
Denominator	*	1,222.00
% Infection Rate		1.80%

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):

This milestone was achieved by June 2012. The surgical site infection rate listed above is an aggregate rate for the time period of July 2011-June 2012 for the three surgical procedures RCRMC has selected for this initiative: C-sections, hernias, and hip prostheses. This information is documented by a report compiled by the hospital's Infection Control and Prevention Department. The individual surgical site infection rates for each procedure during this time period are: C-sections (17/710 = 2.40%); hernias (4/426 = 0.94%); and hip prostheses (1/86 = 1.16%).

These rates represent a significant decline from the baseline number of infections reported by procedure (see milestone below): C-sections (56% reduction); hernias (74% reduction); and hip prostheses (78% reduction). RCRMC staff have made a concerted effort to decrease the number of surgical site infections. In 2009 infection prevention and control staff discovered that the hospital's compliance rate on the Surgical Care Improvement Project (SCIP) core measure was approximately 90% and yet surgical infections were still occurring at a higher than expected rate. A multidisciplinary task force, comprised of physician leadership, surgeons, anesthesiologists, operating room nurse manager, nurses from inpatient units, environmental services staff, and the infection prevention and control staff met to discuss strategies on how the infection rate could be reduced. The first intervention was to have each surgical patient receive a chlorhexidine bath prior to their procedure. A slight improvement in the infection rate occurred as a result.

In July 2010 the taskforce identified and implemented an additional intervention: the use of a surgical bundle comprised of 33 elements derived from evidence-based guidelines from the Center for Disease Control and the Association of periOperative Registered Nurses. These bundle elements focused on six areas: 1) operating room environment; 2) peri-operative patient care procedures; 3) pre-op skin preparation; 4) surgical attire; 5) sterile field; and 6) urinary catheter insertion. Examples of these bundle elements include, but are not limited to: maintaining operating room temperature between 68 degrees F to 73 degrees F; maintaining operating room relative humidity between 35%-60%; glucose level in normal range; hair removal performed before entering the operating room; all operating room staff wear long sleeves; and avoidance of flash sterilization.

After the bundle was developed, surgeons, anesthesiologists, and operating room nurses were educated on the bundle elements and the quality improvement goal of reducing surgical site infection. Infection prevention and control staff then initiated randomized observations of targeted surgeries, including C-sections, hernias, and hip prostheses, to assess the operating room team compliance with the bundle. A checklist was developed which included all bundle elements. About 30 observations are completed per quarter. The task force attributes the significant decline in surgical infections to the randomized observations of surgeries being performed. Quality improvement data pertaining to the randomized observations of targeted surgical procedures are presented to the Surgery Committee, Perinatal Committee, and the Infection Prevention and Control Committee for reviewand development of action plans to address issues.

Continuing education sessions are being rolled out to reinforce the operating room staff's compliance with the surgical bundle. Thus far, training has been held with the Orthopedic Surgery, Neurosurgery, and Obstetrical/Gynecology Departments. Additional sessions are being planned to include other surgical specialties and anesthesiology. Operating room nurses receive continuing education during their weekly meetings.

A key lesson learned is that a culture change is needed to obtain surgeon and other operating room staff compliance with the surgical bundle. A physician champion is proactively working with surgeons to increase their compliance with this bundle. This customized surgical site infection prevention bundle is an intervention that could be shared with other hospitals to impact their surgical infection rate.

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

Category 4: Surgical Site Infection Prevention

Optional Milestone: Report on at least six months of data collection on surgical site infections 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)	*	N/A
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

This milestone was achieved by December 2011. Baseline data were submitted to SNI for each of the three surgical procedures included in this initiative, as documented by: 1) a spreadsheet listing the baseline data and 2) SNI staff's acknowledgement of the data receipt. All data are based on a 12 month time period. Here is the baseline information: C-Sections: The baseline period was July 2009-June 2010. The numerator was 36 and the denominator was 653, with a surgical infection rate of 5.5%. Hernias: The baseline period was July 2009-June 2010. The numerator was 12 and the denominator was 336, with a surgical infection rate of 3.6%. Hip Prostheses: The baseline period was July 2010-June 2011. The numerator was 5 and the denominator was 95, with a surgical infection rate of 5.3%.

Routine surveillance of surgical site infection is conducted by an infection preventionist (IP) in an active, patient-based, prospective, priority-directed manner that yields risk-adjusted incidence rates. Laboratory reports are reviewed to identify patients with possible infections, e.g., positive microbiology cultures or positive pathology findings. In addition, the IP meets with laboratory personnel to identify clusters of patient infections, especially in areas not targeted for routine surveillance. During inpatient rounds, the IP also screens nursing care reports, temperature charts, and antibiotic administration sheets trying to identify patients who might be infected. Chart reviews are performed on patients suspected of having a surgical infection. The following information is reviewed: physician progress notes and nurses notes, laboratory data, radiology/imaging reports, surgery reports, etc. A surgical site infection data collection form/screen is completed as data sources are reviewed.

Denominator data is also collected by the IP which includes counts of the cohorts of patients at risk of acquiring surgical infections. For infection rates stratified by NHSN according to risk, information is collected on operative procedures selected for surveillance (e.g., type of procedure, date, risk factors, etc.). Sources of denominator data are detailed logs from the operating room for each operative procedure.

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: Riverside County Regional Medical Center
REPORTING YEAR: DY 7
DATE OF SUBMISSION: 9/28/2012

Category 4: Stroke Management

REPORTING ON THIS PROJECT: * Yes

Below is the data reported for the DPH system.

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

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

Stroke Management

DY Total Computable Incentive Amount: * $ 2,359,500.00

Incentive Funding Already Received in DY: * $ 589,875.00

Optional Milestone: Designate physician(s) to provide 24/7 program coverage.
(insert milestone)

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

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

This milestone was achieved by June 2012, as evidenced by a management contract. A new neurologist medical group was recruited and began providing 24/7 coverage to support RCRMC's stroke program on 7/1/12.

Stroke is the 3rd leading cause of death and the leading cause of disability. Yet, Riverside County has only two primary stroke centers to serve a population of over 2.2 million people. Patients with stroke symptoms are often transported to hospitals located outside the county for treatment. To meet this community need, RCRMC management and physician leadership set a goal of becoming a primary stroke center as designated by The Joint Commission. The existing neurology medical group was replaced by a new neurology group that could better meet the needs of the stroke program.

With the arrival of the new neurology medical group, consults are now occurring within 15 minutes of request by emergency and internal medicine physicians during normal business hours on weekdays for all hyperacute stroke patients. In the evening and on weekends, consults are conducted by telephone between the treating provider and the on-call neurologist. Verbal information is provided to the neurologist regarding results of diagnostic tests and treatment decisions are made collaboratively between both providers. A stroke telemedicine program is in the planning stages to better address neurology consult coverage after hours and on weekends to better meet the needs of Riverside County residents. Once implemented, the on-call neurologist will conduct an in-depth neurological examination from an offsite location with the assistance of a trained registered nurse at RCRMC via high definition videoconferencing technology. Following this assessment, the neurologist will collaborate with emergency or internal medicine physicians to determine the best patient treatment options available.

One of the challenges to implementing the stroke program has been the use of IV-administered tissue plasminogen activator (tPA) which in many cases can improve patient outcomes if administered within the first three hours of the onset of stroke symptoms. Additional studies currently show that this time window may now exceed three hours and reach up to 4.5 hours with success. Emergency Department physicians expressed concerns about the use of tissue plasminogen activator (tPA) for patients with ischemic stroke. To address their concerns, extensive literature regarding the validity of early interventions for stroke has been presented to the physicians for review and discussion. In addition, the stroke coordinator has scheduled presentations involving other physicians throughout the surrounding area who are currently using this treatment option with success to provide educational support to the RCRMC physician team. A presentation on current stroke neuro-interventions has been scheduled at an upcoming Grand Rounds event.

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

Achievement Value: 1.00

Category 4: Stroke Management

Optional Milestone: Develop uniform practice standards and protocols to effectively manage and coordinate the stroke program.

(insert milestone)

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

This milestone was achieved by June 2012, as documented by the stroke program's policies and procedures which were approved by the Medical Executive Committee in June 2012. Development of the stroke program's practice standards and protocols was initiated in 2011. A multidisciplinary Stroke Leadership Committee was formed to discuss the goal of becoming designated as a primary stroke center by The Joint Commission. This team included representatives from Administration, Neurology, Emergency Department, Nursing, Rehabilitation, Education, Laboratory, Quality Management, and Radiology. It was decided that the stroke program's protocols would be based on the American Heart Association's Get with the Guidelines. It would also comply with The Joint Commission's Disease-Specific Care Certification Manual.

A decision was also made to hire a stroke coordinator whose initial responsibilities would be to coordinate the development of the stroke program's policies and procedures and to train hospital staff on the stroke program's protocols. In late 2011 the stroke coordinator was hired. In terms of qualifications, this individual is a nurse with several years of experience working in the Emergency Department and critical care areas. She has a Masters Degree in Nursing with special emphasis in health education.

The stroke coordinator drafted program policies based on the guidelines referenced above in collaboration with the Stroke Leadership Committee. There were challenges in developing and finalizing these policies. Although input was received from a broad audience as represented by the members of the Stroke Leadership Committee, other key individuals were not initially identified and, as a result, there were multiple revisions of the same policy. As one example, Riverside County's legal counsel should have been included earlier in the policy development process to provide input on informed consent and other issues.

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

Category 4: Stroke Management

Optional Milestone: Designate personnel to establish the multidisciplinary Acute Stroke Team.
(insert milestone)

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

This milestone was achieved as of June 2012, as evidenced by the Medical Executive Committee's approval of the stroke program's policies in June 2012 and human resource documents. At this stage of program implementation, RCRMC is using two dedicated stroke teams to care for hyperacute stroke patients.

One team is based in the emergency department and is composed of an emergency department physician, a National Institute of Health Stroke Scale (NIHSS)-certified registered nurse, a designated clinical pharmacist, and a designated certified nursing assistant. Each team member is trained specifically related to their roles and responsibilities to rapidly recognize stroke symptoms, effectively implement stroke bundles and to effectively manage stroke patients. The second stroke team is comprised of the on-call internal medicine team physician, a NIHSS-certified registered nurse, a designated clinical pharmacist, and a designated certified nursing assistant who respond to any code stroke that occurs in the inpatient setting. This second team is trained the same way to provide a universal standard of stroke care. In addition to covering code stroke calls, members of this designated team respond to calls pertaining to code blues and rapid responses to patients exhibiting a negative change in their health condition.

The use of two separate stroke response teams was initiated out of necessity. RCRMC's Emergency Department is extremely busy, often treating 400 patients in a single day which includes the majority of hyperacute stroke patients who require a medical assessment within 10 minutes of arrival. Providers actively working in the Emergency Department would not be able to leave the department to care for patients that display signs and symptoms of a hyperacute stroke on an inpatient unit. At the same time the inpatient stroke team members would need to leave their current work load and respond to patients that present to the Emergency Department. Many hospitals throughout the region commonly pull from existing critical care teams to meet the needs of the inpatient population with great success. While this "two team" model has been effective in managing stroke patients, future plans include development of an all inclusive "code" response team that would be dedicated to responding to any adverse change in patient status including code stroke, code blue, and rapid response for patients that exhibit a decline in health condition throughout the entire facility. In addition to responding to codes, this team would focus on patient and staff education, promoting the importance of proactive identification and management of high risk patients.

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

Category 4: Stroke Management

Optional Milestone: Train at least 25 multidisciplinary staff on stroke program protocols.
(insert milestone)

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

This milestone was achieved by June 2012, as evidenced by presentation materials and staff sign-in sheets. Approximately 300 staff members have been trained. These individuals include physicians, nurses, certified nursing assistants, clinical pharmacists, physician assistants, and social workers. Training topics have included the following information:

• stroke recognition and triage, including neurological assessment using the National Institute of Health Stroke Scale (NIHSS);

• stroke pathophysiology;

• stroke diagnostic studies;

• early stroke treatment, including the administration of tissue plasminogen activator (tPA);

• stroke patient management, including contraindications;

• recognition, assessment, and management of acute stroke complications; and

• stroke dysphagia training to minimize patient risk of aspiration.

As a result of this education, patients who arrive at RCRMC with stroke symptoms are rapidly assessed by a nurse and physician within ten minutes of arrival. Diagnostic tests, including CT scans and lab tests are completed within 25 minutes and results are reported within 45 minutes. Treatment decisions and care plan implementation are completed in a timely manner and patients are admitted as appropriate to their medical condition.

One of the challenges to providing stroke education and keeping hospital staff current on the program's protocols is that the hospital depends on the use of travel and registry personnel to address the current nursing shortage and to meet the needs of RCRMC's growing patient population. To address this issue, comprehensive stroke education is provided on a continuous basis. Travel and registry nurses receive a four hour orientation specific to the Emergency Department, including stroke education, which is in addition to the required general hospital orientation. Self-study stroke program orientation packets, including tests and competencies, are being developed. This information will be given to all new clinical staff who will be required to submit completed tests and demonstration competencies within one week of hire. To reinforce training efforts, future plans include having stroke education information available on the hospital's intranet website so staff can access it at any time.

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

Category 4: Stroke Management

Optional Milestone: Report at least six months of data collection on the seven stroke management process measures to SNI for purposes of establishing the baseline and setting benchmarks.

(insert milestone)

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

This milestone was achieved by December 2011. Baseline data for the seven stroke management process measures, for the time period of July 2009-June 2010, were submitted to SNI, as documented by: 1) a spreadsheet listing the baseline data and 2) SNI staff's acknowledgement of the data receipt. Here are the compliance rates for each measure: Discharged on Antithrombotic Therapy (102/103 = 99.0%); Anticoagulation Therapy for Atrial Fibrillation/Flutter (10/10 = 100%); Thrombolytic Therapy (3/6 = 50%); Antithrombotic Therapy by End of Hospital Day 2 (101/101 = 100%); Discharged on Statin Medication (98/103 = 95.1%); Stroke Education (88/117 = 75.2%) and Assessed for Rehabilitation (123/124 = 99.2%).

To summarize the data collection process, a quality management nurse identifies all cases that would pertain to the stroke population as defined by the CMS/The Joint Commission (TJC) Specifications Manual for National Hospital Inpatient Quality Measures, including patients with ischemic stroke and hemorrhagic stroke. The nurse performs a monthly query in the University HealthSystem Consortium (UHC) clinical data base to identify the inpatient discharges that fall into this population. She reviews 100% of the cases; there is no sampling. At the time this baseline information was collected, data was obtained from manual paper chart abstraction and compliance rates were maintained manually on paper-based abstraction tools. Results were entered into an Excel spreadsheet on the standard RCRMC core measure dashboard for review by the Performance Improvement Committee.

Data collection and reporting practices have been improved since 2009. Data are abstracted from the patient's "hybrid" chart which is a combination of a paper chart and the Soarian electronic health record. It is then entered into the American Heart Association's (AHA) Get with the Guidelines (GWTG) – Stroke online abstraction tool. This tool is more detailed in the data required to be abstracted than the CMS/TJC core measure set; all are based on evidence-based best practice. Reports containing the additional data from the AHA/GWTG-Stroke tool are shared with the stroke work teams and the stroke coordinator to improve the hospital's stroke program.

To ensure data integrity, the quality management nurse runs a quarterly "Data Quality Report" from the AHA/GWTG-Stroke online tool prior to preparing any internal dashboard or external reports. This report determines if there are any data integrity issues with the patient cases abstracted such as duplicate case entries, out of range data, missing clinical data, and inconsistencies with dates. If errors are discovered, information is re-abstracted to ensure all documented elements are entered into the online tool.

RCRMC stroke measure compliance rates are pulled from the AHA/GWTG-Stroke tool and entered into the RCRMC standard core measure dashboard for internal review by the stroke work group which includes the quality management nurse, neurologist, and stroke coordinator. Opportunities to improve are shared with stakeholders accountable for the process to develop and implement action plans for improvement. The results are then presented to the Performance Improvement Committee on a quarterly basis.

The stroke core measure set will become a mandatory reported data set to CMS effective with 1/1/13 discharges. RCRMC will be using AHA/GWTG-Stroke as its core measure vendor to submit the required information. The AHA/GWTG-Stroke has developed the "Submission Error Report" as an additional data reliability check to identify any data issues. RCRMC staff has used this new report for internal purposes and to date data errors have not been detected.

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

Category 4: Stroke Management

Optional Milestone: Report the data to the State.
(insert milestone)

Numerator (if N/A, use "yes/no" form below; if absolute number, enter here)	*	7.00
Denominator (if absolute number, enter "1")	*	7.00
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

This milestone has been fully achieved as of June 2012, as evidenced by the stroke core measures dashboard. Partial reporting, which included data from the July-December 2011 time period was included in the March 2012 report. The compliance rates, including the numerator and denominator, for each stroke measure for the full DY 7 year (7/1/11 – 6/30/12) are: Discharged on Antithrombotic Therapy (133/133 = 100%); Anticoagulation Therapy for Atrial Fibrillation/Flutter (8/8 = 100%); Thrombolytic Therapy (2/8 = 14%); Antithrombotic Therapy by End of Hospital Day 2 (140/140 = 100%); Discharged on Statin Medication (112/113 = 98%); Stroke Education (138/144 = 99%); and Assessed for Rehabilitation (180/186 = 97%).

RCRMC's Stroke Leadership Committee regularly reviews compliance with the stroke measures. This committee is comprised of representatives from neurology, neurosurgery, emergency medicine, internal medicine, pharmacy, rehabilitation services, social work, case management, administration, quality management, food and nutrition services, and chaplain services. Several performance improvement projects are underway to improve stroke measure compliance, using the Plan-Do-Study-Act (PDSA) model. One example pertains to lab turnaround time. The goal was to decrease the amount of time it took to receive, process, and report lab results, from the current 2-3 hours to 45 minutes, per The Joint Commission standards. Upon review, it was determined that a method was needed to alert the lab staff other than by pager regarding urgent lab requests. Two process changes were implemented: the color of the lab slip was changed to denote an urgent request and a certified nursing assistant hand-delivered the lab slip and specimen directly to the clinical lab scientist. To support this change, the stroke coordinator provided education to nurses, certified nursing assistants, clinical lab scientists, and department managers. Through these interventions the lab turnaround time was reduced to 45 minutes on average.

In comparing baseline data from 2009-2010 to the current period, the compliance for thrombolytics decreased. Although most stroke patients are not candidates for thrombolytics, there was a lack of documentation supporting this fact. Physicians were not documenting this information appropriately in the medical record. Extensive education has been provided to physicians about acceptable exclusion criteria and how it must be documented which has contributed to overall compliance improvement. In addition, the percentage of patients receiving stroke education has increased significantly when compared to baseline data. This increase is a direct result of comprehensive staff training on the importance of providing patient and family education on stroke risk factors, early signs and symptoms of stroke, and the need to contact 911 as soon as stroke symptoms occur.

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