

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid, CHIP, and Survey & Certification

APR 07 2011

Toby Douglas
Chief Deputy Director, Health Care Programs
Department of Health Care Services
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 99859

Dear Mr. Douglas:

We are pleased to inform you that the Centers for Medicare and Medicaid Services (CMS) has completed its review of the "Category 3" improvements entitled, "Patient focused Improvements" to the Delivery System Reform Incentive Payments (DSRIP) metrics (attachment Q) of the State of California's Medicaid section 1115 demonstration special terms and conditions (Waiver 11-W-00193/9).

The demonstration's special term and condition (STC) 35(c) required the State to develop and obtain CMS approval for attachment Q in the creation of a DSRIP. The DSRIP is available to the State for the development of a program of health reform activity and hospital system improvements that supports California's public/safety net hospitals' efforts in meaningfully enhancing the quality of care and the health of the patients and families they serve.

Our review indicates that the enclosed Attachment Q, Patient focused Improvements to the DSRIP Protocol complies with the requirements outlined within special term and condition 35(c).

We would like to thank you and your staff for working with us on this requirement, and we look forward to continuing our collaborative efforts.

Sincerely,

A handwritten signature in blue ink that reads "Cindy Mann". The signature is written in a cursive, flowing style.

Cindy Mann
Director

Enclosures

cc: Dianne Heffron, CMCS
Victoria Wachino, CMCS
Gloria Nagle, San Francisco Regional Office
Steven C. Rubio, CMCS

Category 3 - Population-focused Improvement

I. Introduction

As defined within these California Section 1115 Demonstration STCs, the purpose of Category 3: Population-focused Improvement is to provide “investments in enhancing care delivery for the 5-10 highest burden (morbidity, cost, prevalence, etc.) conditions in public hospital systems for the population in question. Examples of such initiatives drawn from the CAPH hospitals’ initial proposals are: A. Improved Diabetes Care Management and Outcomes; B. Improved Chronic Care Management and Outcomes; C. Reduction of Readmissions; and D. Improved Quality (with attention to reliability and effectiveness, and targeted to particular conditions or high-burden problems).”

The measure set below for Category 3 includes measures that are:

- A. Aligned with the low-income, Medicaid, and uninsured population in question;
- B. Identified as high priority given the health care needs and issues of the patient population served by DPH systems; and
- C. Viewed as valid health care indicators to inform and fuel improvements in population health within the health care safety net.

II. Category 3 Structure

- A. Each DPH system plan will include each required measure listed below as milestones in the 5-year plan.
- B. Each DPH system plan will include Category 3 milestones for DY 7-10, as specified per domain below.
- C. With the Category 3 emphasis on the reporting of population health measures to gain information and understanding on the health status of key populations and to build the capacity for reporting on a comprehensive set of population health metrics, DPH systems will measure and report on the below measures within each of the below five domains, but will not have milestones associated with the achievement of specific improvements.

III. Category 3 Reporting of Data Measures – Five Domains:

A. Patient/Care Giver (CG) Experience

All of the CG Consumer Assessment of Healthcare Providers and Systems (CAHPS) questions included for the themes listed below are required to be included in DPH system plans for DY 8-10. For DY 8 only, data from the last 2 quarters of the demonstration year shall suffice to meet the DY 8 reporting requirement to allow for DPH systems to put in place CG CAHPS and the related data and logistics. Full demonstration year data for DY 9 and 10 is required.

1. Data Source: CG CAHPS¹

¹ See: http://www.cahps.ahrq.gov/cahpskit/files/309-4_CG_Reporting_Measures_4pt.pdf

2. Each CG CAHPS theme includes a standard set of questions. The following CG CAHPS' themes will be reported on:
 - a. Getting Timely Appointments, Care, and Information
 - b. How Well Doctors Communicate With Patients
 - c. Helpful, Courteous, and Respectful Office Staff
 - d. Patients' Rating of the Doctor
 - e. Shared Decision making
3. The reporting of the measures must be limited to ambulatory care clinics only.

B. Care Coordination

DPH system plans must include 2 measures in DY 7 (#6 - 7) and all measures in DY 8-10:

1. Potential Inpatient Data Sources: Inpatient discharge diagnoses, hospital computer system, medical records, claims, registry and/or ambulatory care EMR (if available)
2. Measurement: The data for measurement will be extracted from one of the following ambulatory care data sources:
 - a. Manually, using a sampling approach;²
 - b. A registry with a minimum of 325 patient records system-wide to align with the number of records needed for statistical sampling. All applicable patient records will be reported (not a sample).
 - c. A data warehouse;
 - d. A practice management system; or
 - e. An electronic medical record (EMR)
 - i. Diabetes, short-term complications (derived from AHRQ Prevention Quality Indicator (PQI) #1)³
 - A. **Metric:**
 1. **Numerator:** All inpatient discharges from the DPH system of patients age 18 – 75 years⁴ with ICD-9-CM principal diagnosis code for short-term complications (ketoacidosis, hyperosmolarity, coma) within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
 2. **Denominator:** Number of patients age 18 – 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
 - ii. Uncontrolled Diabetes (derived from AHRQ Prevention Quality Indicator (PQI) #14)⁵
 - A. **Metric:**
 1. **Numerator:** All inpatient discharges from the DPH system of patients age 18 – 75 years with ICD-9-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication

² See Appendix A: Sampling Approach

³ Derived from:

<http://www.qualitymeasures.ahrq.gov/content.aspx?id=15408&search=Diabetes+Mellitus%2C+Type+1>

⁴ Age 18-75 is how HEDIS defines eligible diabetics.

⁵ Derived from: <http://www.qualitymeasures.ahrq.gov/content.aspx?id=15425>

- within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
2. **Denominator:** Number of patients age 18 – 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
- iii. Congestive Heart Failure (derived from AHRQ Prevention Quality Indicator (PQI) #8)⁶
- A. Metric:**
1. **Numerator:** All inpatient discharges from the DPH system of patients age 18 years and older with ICD-9-CM principal diagnosis code for CHF within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
 2. **Denominator:** Number of patients age 18 years and older who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
- iv. Chronic Obstructive Pulmonary Disease (derived from AHRQ Prevention Quality Indicator (PQI) #5)⁷
- A. Metric:**
1. **Numerator:** All inpatient discharges from the DPH system of patients age 18 years and older with ICD-9-CM principal diagnosis code for COPD within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
 2. **Denominator:** Number of patients age 18 years and older with COPD who have visited the DPH system primary care clinic(s) two or more times in the past 12 months

C. Patient Safety

Category 4 shall deem to meet this domain.

D. Preventive Health

DPH system plans must include 2 measures in DY 7 (#10-11) and all measures in DY 8-10:

1. Data Source: Registry, ambulatory care EMR, practice management system, and/or another data source as specified by the DPH system
2. Measurement: The data for measurement will be extracted from one of the following sources:
 - a. Manually, using a sampling approach;⁸
 - b. A registry with a minimum of 325 patient records system-wide to align with the number of records needed for statistical sampling. All applicable patient records will be reported (not a sample);
 - c. A data warehouse;
 - d. A practice management system; or

⁶ Derived from: <http://www.qualitymeasures.ahrq.gov/content.aspx?id=15419>

⁷ Derived from: <http://www.qualitymeasures.ahrq.gov/content.aspx?id=9041>

⁸ See Appendix A: Sampling Approach

- e. An electronic medical record (EMR)
- i. Mammography Screening for Breast Cancer⁹
 - A. Metric:**
 - 1. **Numerator:** All female patients age 50 – 74 years¹⁰ who had a mammogram to screen for breast cancer within 24 months who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
 - 2. **Denominator:** Number of female patients age 50 – 74 years who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
- ii. Influenza Immunization¹¹
 - A. Metric:**
 - 1. **Numerator:** All patients age 50 and older who received an influenza immunization during the flu season (September through February) who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
 - 2. **Denominator:** Number of patients age 50 and older who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
- iii. Child Weight Screening
 - A. Metric:**
 - 1. **Numerator:** All patients age 2 – 18 years with a calculated BMI documented in the medical record within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
 - 2. **Denominator:** Number of patients age 2 – 18 years who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
- iv. Pediatrics Body Mass Index (BMI)¹²
 - A. Metric:**
 - 1. **Numerator:** All patients age 2 – 18 years with a BMI above the 85th percentile within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
 - 2. **Denominator:** Number of patients age 2 – 18 years who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
- v. Tobacco Cessation¹³
 - A. Metric:**
 - 1. **Numerator:** Number of patients 18 years and older who screened positive for tobacco use and who received or were referred to cessation counseling within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months

⁹ Derived from: <http://www.qualitymeasures.ahrq.gov/content.aspx?id=14620>

¹⁰ The age range as per the U.S. Preventive Services Task Force:
<http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm>.

¹¹ Derived from: <http://www.qualitymeasures.ahrq.gov/content.aspx?id=14991>

¹² Please reference: http://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html

¹³ Derived from: <http://qualitymeasures.ahrq.gov/content.aspx?id=14635>

2. **Denominator:** Number of patients 18 years and older who screened positive for tobacco use who have visited the DPH system primary care clinic(s) two or more times in the past 12 months

E. At-Risk Populations

DPH system plans must include 2 measures in DY 7 (#15-16) and all measures in DY 8-10. For measures #20-21, in DY 8, DPH systems will report a minimum of two quarters of data (not a full year's worth of data) to provide more time to further develop their ability to do the reporting, develop the reporting processes, test the processes, and work out the reporting and data challenges that come with reporting a new measure:

1. **Data Source:** Registry, ambulatory care EMR, practice management system, and/or another data source as specified by the DPH system
2. **Measurement:** The data for measurement will be extracted from one of the following sources:
 - a. Manually, using a sampling approach;¹⁴
 - b. A registry with a minimum of 325 patient records system-wide to align with the number of records needed for statistical sampling. All applicable patient records will be reported (not a sample);
 - c. A data warehouse;
 - d. A practice management system; or
 - e. An electronic medical record (EMR)

- i. **Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl)¹⁵**

A. Metric:

1. **Numerator:** All patients age 18 – 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dl) within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
2. **Denominator:** Number of patients age 18 – 75 years with diabetes mellitus who have visited the DPH system primary care clinic(s) two or more times in the past 12 months

- ii. **Diabetes Mellitus: Hemoglobin A1c Control (<9%)¹⁶**

A. Metric:

1. **Numerator:** All patients age 18 – 75 years with diabetes whose most recent hemoglobin A1c level is in control (<9%) within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
2. **Denominator:** Number of patients age 18 – 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months

- iii. **30-Day Congestive Heart Failure Readmission Rate**

A. Metric:

¹⁴ See Appendix A: Sampling Approach

¹⁵ Derived from: http://www.hmohelp.ca.gov/healthplans/gen/gen_rci.aspx

¹⁶ Derived from: http://www.hmohelp.ca.gov/healthplans/gen/gen_rci.aspx

1. **Numerator:** All patients age 18 years and older who experience a readmission for related conditions within 30 days of discharge for an original admission with ICD-9-CM principal diagnosis code for CHF within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months¹⁷
 2. **Denominator:** Number of patients age 18 years and older with CHF who have visited the DPH system primary care clinic(s) two or more times in the past 12 months¹⁸ and had an admission
- iv. Hypertension (HTN): Blood Pressure Control (<140/90 mmHg)
- A. Metric:**
1. **Numerator:** Number of patients age 18 – 75 years with a diagnosis of hypertension with the most recent blood pressure level (in clinic or with ambulatory blood pressure monitoring) in control (less than 140/90 mmHg) within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
 2. **Denominator:** Number of patients age 18 – 75 years with a diagnosis of hypertension who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
- v. Pediatrics Asthma Care¹⁹
- A. Metric:**
1. **Numerator:** Number of patients age 5 – 18 with persistent asthma who were prescribed at least one controller medication for asthma therapy within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
 2. **Denominator:** Number of patients age 5 – 18 with persistent asthma who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
- vi. Optimal Diabetes Care Composite (Minnesota Community Measurement as adopted by the National Quality Forum)²⁰
- A. Metric:** The percentage of adult diabetes patients who have optimally managed modifiable risk factors with the intent of preventing or reducing future complications associated with poorly managed diabetes
1. **Numerator:** Number of patients ages 18 – 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months

¹⁷ Exclusion: planned readmissions (for example, chemotherapy schedule, radiation, rehab, planned surgery, renal dialysis, blood transfusions). “Related conditions” will be defined consistently for all DPH systems, (e.g., 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93 and 428.XX).

¹⁸ Exclusions: labor and delivery, transfers to another acute care hospital, patients who die before discharge

¹⁹ Derived from: <http://qualitymeasures.ahrq.gov/content.aspx?id=23966&search=asthma> and http://www.nhlbi.nih.gov/guidelines/asthma/08_sec4_lt_0-11.pdf. Exclusions include: Patients diagnosed with emphysema or chronic obstructive pulmonary disease (COPD), cystic fibrosis or acute respiratory failure any time on or prior to December 31 of the measurement year.

²⁰ See: <http://www.goapic.org/Presentations/NQFDraft1010.pdf>

2. **Denominator:** Number of patients ages 18 – 75 with a diagnosis of diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
- vii. Diabetes Composite (National Committee for Quality Assurance as adopted by the National Quality Forum)²¹
- A. **Metric:** The percentage of individuals 18 – 75 years of age with diabetes (type 1 and type 2) who had each of the endorsed component measures included in the composite
 1. **Numerator:** Number of patients ages 18 – 75 with a diagnosis of diabetes (type 1 and type 2), who had each of the numerator component measures within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
 2. **Denominator:** Number of patients ages 18 – 75 with a diagnosis of diabetes (type 1 and type 2), who have visited the DPH system primary care clinic(s) two or more times in the past 12 months

IV. Appendix A: Sampling Approach

A sampling approach can be applied to generate a statistically significant random sample:

- A. If there are up to 200 patients, then include all 200 patients to define the numerator;
- B. If there are 201-500 patients, then include a simple random sample of 201 patients to define the numerator;
- C. If there are 501-1,000 patients, then include 275 patients in the random sample to define the numerator; or
- D. If there are more than 1,000 patients, then include 325 patients in the random sample to define the numerator.

This methodology employs a standard calculation with 95% accuracy (the sample size groupings are generated based on a P value of approximately 0.05, per <http://www.surveysystem.com/sscalc.htm>).

²¹ See <http://www.goapic.org/Presentations/NQFDraft1010.pdf>