**ARROWHEAD REGIONAL MEDICAL CENTER**

**ADDENDUM TO DSRIP FIVE-YEAR PLAN SUBMITTEDFEBRUARY 18, 2011**

**CATEGORY 3: POPULATION-FOCUSED IMPROVEMENT REPORTING MEASURES**

**April 15, 2011**

**Narrative:**

Arrowhead Regional Medical Center (ARMC) is committed to improving its patient population as a whole. Through reporting on Category 3 milestones, ARMC will focus its efforts on improving its Patient/Care Giver Experience, Care Coordination, Preventative Health and At-Risk Populations. All of the elements necessary to improve our patient population’s health have been methodically described in our Category 1 and 2 DSRIP document and are evidenced in the reporting structure of Category 3. Specifically;

1. Expanding Primary Care Capacity will assist aspects of at least three domains: 1) timely access to appointments will improve patient experience; 2) ability to see more patients will increase the number of hospital discharges that can be cared for in our primary care clinics improving care coordination; 3) ability to see more patients will increase the number of patients receiving required preventive health services; and 4) improving access.
2. Increase Training of Primary Care Workforce by expanding the size of our primary care residency program. By DY 10, ARMC will have recruited and hired 6 additional primary care residents over the current baseline to help address the substantial primary care workforce shortage. These new residents will be trained in the fundamental aspects of the medical home and chronic care models, allowing ARMC to improve health outcomes in preventative care and chronic disease. An expanded primary care workforce will increase access and capacity to ARMC’s care services, thereby improving the patient experience and care coordination. Additional providers in the Primary Care Clinics (Family Health Centers) provide the ability to see patients immediately (2 to 3 days) post-acute care discharge for necessary follow-up.
3. Implement and Utilize Disease Management Registry Functionality to effectively manage and coordinate patient care for individuals identified in registry. Through the use of registry, ARMC will impact all domains: 1) communication between patients and their physicians and shared decision making for patients entered into the disease registry will be supported improving the patient experience; 2) registry reports will enhance care coordination and preventive services for these patients; 3) registry reports allow the system to track all patients in a specific at-risk diagnosis ; and 4) registry reports will facilitate necessary data gathering for quality measures related to Category 3. Overall, the use of registries will improve outpatient management of chronic conditions, leading to better health outcomes in both preventative services and decreased disabilities of patients with the specified chronic conditions.
4. Expand Specialty Care Capacity to facilitate timely access to specialty care to address medical problems before they progress to advanced stages which are more recalcitrant to care. Efficient exchange of information between primary care and specialist providers can help identify those patients whose conditions can be managed in a primary care environment with simple guidance from the specialist; and those patients who require more comprehensive specialty evaluation and treatment. Streamlining and expanding specialty care access is a critical component towards ensuring both the global and individual health of our patient population.
5. Expand Medical Homes by appropriately embedding the model into our delivery care system so that all patients receive the right care in the right place at the right time. Using the medical home model impacts all four domains as it will allow us to comprehensively manage our patients to promote compliance with evidence-based guidelines, improve the patient’s experience and possibly decrease the cost of care by allowing all members of the team to operate at the top of their license. Specifically, the model is characterized by better access to needed services, improved quality of care, a greater focus on prevention and an early identification and management of health problems. A strategic component to the Medical Home Model will be the use of panel management which is a series of processes with the goal of improving the chronic and preventive care for ARMC’s empaneled patients. Utilizing the Medical Home Model at ARMC will enhance the process and ability for the patient and their family to actively participate in their treatment and care plan – resulting in improved patient experience, as well as improved patient outcomes through evidence based interventions.
6. Expand Chronic Care Management Models impacts all four domains with an emphasis on the At-Risk Population domain. The Chronic Care Model redesigns the primary care delivery system in order to provide appropriately coordinated care that supports patient self-management, meets accepted disease management guidelines leading to improved health outcomes, meets accepted preventive care indicators, meets accepted patient education indicators and increases shared decision-making. Studies have shown that the more patients and their families are informed and educated about disease prevention and treatment, the more compliant they are with their treatment plan; resulting in improved health outcomes. Interactive and consistent education between our care teams and the patient/family will be crucial to our successes.
7. The Redesign Primary Care initiative particularly impacts the first domain of improving the patient experience. Redesign has been shown to improve both patient and provider satisfaction. In addition to Redesign, ARMC is currently in the process of reviewing vendors to provide patient satisfaction surveys and reporting, including HCAHPS. Our goal is to continuously improve our patient experience through a series of multi-disciplinary customer service training classes throughout the hospital.

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| **Patient/Care Giver Experience** |
| **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** |
|  | 1. **Undertake the necessary planning, redesign, translation, training and contract negotiations in order to implement CG-CAHPS in DY8.**
 | 1. **Report results of CG CAHPS questions for “Getting Timely Appointments, Care, and Information” theme for at least data from the last two quarters of the demonstration year to the State**
2. **Report results of CG CAHPS questions for “How Well Doctors Communicate With Patients” theme for at least data from the last two quarters of the demonstration year to the State**
3. **Report results of CG CAHPS questions for “Helpful, Courteous, and Respectful Office Staff” theme for at least data from the last two quarters of the demonstration year to the State**
4. **Report results of CG CAHPS questions for “Patients’ Rating of the Doctor” theme for at least data from the last two quarters of the demonstration year to the State**
5. **Report results of CG CAHPS questions for “Shared Decision-making” theme for at least data from the last two quarters of the demonstration year to the State**
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2. **Report results of CG CAHPS questions for “How Well Doctors Communicate With Patients” theme to the State**
3. **Report results of CG CAHPS questions for “Helpful, Courteous, and Respectful Office Staff” theme to the State**
4. **Report results of CG CAHPS questions for “Patients’ Rating of the Doctor” theme to the State**
5. **Report results of CG CAHPS questions for “Shared Decision-making” theme to the State**
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2. **Report results of CG CAHPS questions for “How Well Doctors Communicate With Patients” theme to the State**
3. **Report results of CG CAHPS questions for “Helpful, Courteous, and Respectful Office Staff” theme to the State**
4. **Report results of CG CAHPS questions for “Patients’ Rating of the Doctor” theme to the State**
5. **Report results of CG CAHPS questions for “Shared Decision-making” theme to the State**
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| **Care Coordination** |
| **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** |
|  | 1. **Report results of the Diabetes, short-term complications measure to the State**
2. **Report results of the Uncontrolled Diabetes measure to the State**
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2. **Report results of the Uncontrolled Diabetes measure to the State**
3. **Report results of the Congestive Heart Failure measure to the State**
4. **Report results of the Chronic Obstructive Pulmonary Disease measure to the State**
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2. **Report results of the Uncontrolled Diabetes measure to the State**
3. **Report results of the Congestive Heart Failure measure to the State**
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3. **Report results of the Congestive Heart Failure measure to the State**
4. **Report results of the Chronic Obstructive Pulmonary Disease measure to the State**
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Care Coordination Denominator:

The following are the DPH system primary care clinic(s):

1. **McKee Family Health Center**
2. **Fontana Family Health Center**
3. **Westside Family Health Center**

Additionally, in order for there to be consistent reporting across DPH systems, the “past 12 months” for all care coordination measures will be defined as the prior demonstration year (July 1 – June 30 of the prior year).

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| **Preventive Health** |
| **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** |
|  | 1. **Report results of the Mammography Screening for Breast Cancer measure to the State**
2. **Reports results of the Influenza Immunization measure to the State**
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2. **Reports results of the Influenza Immunization measure to the State**
3. **Report results of the Child Weight Screening measure to the State**
4. **Report results of the Pediatrics Body Mass Index (BMI) measure to the State**
5. **Report results of the Tobacco Cessation measure to the State**
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4. **Report results of the Pediatrics Body Mass Index (BMI) measure to the State**
5. **Report results of the Tobacco Cessation measure to the State**
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Preventive Health Denominator:

The following are the DPH system primary care clinic(s):

1. **McKee Family Health Center**
2. **Fontana Family Health Center**
3. **Westside Family Health Center**

Additionally, in order for there to be consistent reporting across DPH systems, the “past 12 months” for all preventive health measures will be defined as the prior demonstration year (July 1 – June 30 of the prior year).i

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| **At-Risk Populations** |
| **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** |
|  | 1. **Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State**
2. **Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State**
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2. **Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State**
3. **Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State**
4. **Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State**
5. **Report results of the Pediatrics Asthma Care measure to the State**
6. **Report results of the Optimal Diabetes Care Composite for at least data from the last two quarters of the demonstration year to the State**
7. **Report results of the Diabetes Composite for at least data from the last two quarters of the demonstration year to the State**
 | 1. **Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State**
2. **Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State**
3. **Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State**
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5. **Report results of the Pediatrics Asthma Care measure to the State**
6. **Report results of the Optimal Diabetes Care Composite to the State**
7. **Report results of the Diabetes Composite to the State**
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At-Risk Populations Denominator:

The following are the DPH system primary care clinic(s):

1. **McKee Family Health Center**
2. **Fontana Family Health Center**
3. **Westside Family Health Center**

Additionally, in order for there to be consistent reporting across DPH systems, the “past 12 months” for all at-risk populations measures will be defined as the prior demonstration year (July 1 – June 30 of the prior year).i **Category 3 Five-Year Incentive Payment Table**

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| --- | --- | --- | --- | --- | --- |
|  | DY 6 | DY 7 | DY 8 | DY 9 | DY 10 |
| Category 3 |
| Patient/Care Giver Experience | - | $3,861,000 | $5,148,000 | $7,722,000 | $9,009,000 |
| Care Coordination | - | $3,861,000 | $5,148,000 | $7,722,000 | $9,009,000 |
| Preventive Health | - | $3,861,000 | $5,148,000 | $7,722,000 | $9,009,000 |
| At-Risk Populations | - | $3,861,000 | $5,148,000 | $7,722,000 | $9,009,000 |