Contra Costa Regional Medical Center and Health Centers

ADDENDUM TO DSRIP FIVE-YEAR PLAN SUBMITTED *ON FEBRUARY 18, 2011*

CATEGORY 3: POPULATION-FOCUSED IMPROVEMENT REPORTING MEASURES

Submitted: April 14, 2011

Revised Submission on April 18, 2011

Patient/Care Giver Experience				
Year 1 (11/1/2010 – 6/30/2011)	**Year 2** (7/1/2011 – 6/30/2012)	**Year 3** (7/1/2012 – 6/30/2013)	**Year 4** (7/1/2013 – 6/30/2014)	**Year 5** (7/1/2014 – 6/30/2015)
	133. **Milestone**: Undertake the necessary planning, redesign, translation, training and contract negotiations in order to implement CG-CAHPS in DY8.	134. **Milestone**: 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 135. **Milestone:** 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 136. **Milestone:** 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 137. **Milestone:** 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 138. **Milestone:** Report results of CG CAHPS questions for "Shared Decisionmaking" theme for at least data from the last two quarters of the demonstration year to the State	139. **Milestone**: Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme to the State 140. **Milestone:** Report results of CG CAHPS questions for "How Well Doctors Communicate With Patients" theme to the State 141. **Milestone:** Report results of CG CAHPS questions for "Helpful, Courteous, and Respectful Office Staff" theme to the State 142. **Milestone:** Report results of CG CAHPS questions for "Patients' Rating of the Doctor" theme to the State 143. **Milestone:** Report results of CG CAHPS questions for "Shared Decisionmaking" theme to the State	144. **Milestone:** Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme to the State 145. **Milestone:** Report results of CG CAHPS questions for "How Well Doctors Communicate With Patients" theme to the State 146. **Milestone:** Report results of CG CAHPS questions for "Helpful, Courteous, and Respectful Office Staff" theme to the State 147. **Milestone:** Report results of CG CAHPS questions for "Patients' Rating of the Doctor" theme to the State 148. **Milestone:** Report results of CG CAHPS questions for "Shared Decisionmaking" theme to the State

Care Coordination				
Year 1 (11/1/2010 – 6/30/2011)	**Year 2** (7/1/2011 – 6/30/2012)	**Year 3** (7/1/2012 – 6/30/2013)	**Year 4** (7/1/2013 – 6/30/2014)	**Year 5** (7/1/2014 – 6/30/2015)
	149. **Milestone:** Report results of the Diabetes, short-term complications measure to the State 150. **Milestone:** Report results of the Uncontrolled Diabetes measure to the State	151. **Milestone:** Report results of the Diabetes, short-term complications measure to the State 152. **Milestone:** Report results of the Uncontrolled Diabetes measure to the State 153. **Milestone:** Report results of the Congestive Heart Failure measure to the State 154. **Milestone:** Report results of the Chronic Obstructive Pulmonary Disease measure to the State	155. **Milestone:** Report results of the Diabetes, short-term complications measure to the State 156. **Milestone:** Report results of the Uncontrolled Diabetes measure to the State 157. **Milestone:** Report results of the Congestive Heart Failure measure to the State 158. **Milestone:** Report results of the Chronic Obstructive Pulmonary Disease measure to the State	159. **Milestone:** Report results of the Diabetes, short-term complications measure to the State 160. **Milestone:** Report results of the Uncontrolled Diabetes measure to the State 161. **Milestone:** Report results of the Congestive Heart Failure measure to the State 162. **Milestone:** Report results of the Chronic Obstructive Pulmonary Disease measure to the State

Care Coordination Denominator:

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

1. *Antioch Health Center*
2. *Bay Point Health Center*
3. *Brentwood Health Center*
4. *Concord Health Center*
5. *Martinez Health Center*
6. *North Richmond Center for Health*
7. *Pittsburg Health Center*
8. *Richmond 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).[i]

Preventive Health				
Year 1	**Year 2** (7/1/2011 – 6/30/2012)	**Year 3** (7/1/2012 – 6/30/2013)	**Year 4** (7/1/2013 – 6/30/2014)	**Year 5** (7/1/2014 – 6/30/2015)
	163. **Milestone:** Report results of the Mammography Screening for Breast Cancer measure to the State 164. **Milestone:** Reports results of the Influenza Immunization measure to the State	165. **Milestone:** Report results of the Mammography Screening for Breast Cancer measure to the State 166. **Milestone:** Reports results of the Influenza Immunization measure to the State 167. **Milestone:** Report results of the Child Weight Screening measure to the State 168. **Milestone:** Report results of the Pediatrics Body Mass Index (BMI) measure to the State 169. **Milestone:** Report results of the Tobacco Cessation measure to the State	170. **Milestone:** Report results of the Mammography Screening for Breast Cancer measure to the State 171. **Milestone:** Reports results of the Influenza Immunization measure to the State 172. **Milestone:** Report results of the Child Weight Screening measure to the State 173. **Milestone:** Report results of the Pediatrics Body Mass Index (BMI) measure to the State 174. **Milestone:** Report results of the Tobacco Cessation measure to the State	175. **Milestone:** Report results of the Mammography Screening for Breast Cancer measure to the State 176. **Milestone:** Reports results of the Influenza Immunization measure to the State 177. **Milestone:** Report results of the Child Weight Screening measure to the State 178. **Milestone:** Report results of the Pediatrics Body Mass Index (BMI) measure to the State 179. **Milestone:** Report results of the Tobacco Cessation measure to the State

Preventive Health Denominator:

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

1. *Antioch Health Center*
2. *Bay Point Health Center*
3. *Brentwood Health Center*
4. *Concord Health Center*
5. *Martinez Health Center*
6. *North Richmond Center for Health*
7. *Pittsburg Health Center*
8. *Richmond 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]

At-Risk Populations				
Year 1	**Year 2** (7/1/2011 – 6/30/2012)	**Year 3** (7/1/2012 – 6/30/2013)	**Year 4** (7/1/2013 – 6/30/2014)	**Year 5** (7/1/2014 – 6/30/2015)
	180. **Milestone:** Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State 181. **Milestone:** Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State	182. **Milestone:** Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State 183. **Milestone:** Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State 184. **Milestone:** Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State 185. **Milestone:** Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State 186. **Milestone:** Report results of the Pediatrics Asthma Care measure to the State 187. **Milestone:** Report results of the Optimal Diabetes Care Composite for at least data from the last two quarters of the demonstration year to the State 188. **Milestone:** Report results of the Diabetes Composite for at least data from the last two quarters of the demonstration year to the State	189. **Milestone:** Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State 190. **Milestone:** Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State 191. **Milestone:** Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State 192. **Milestone:** Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State 193. **Milestone:** Report results of the Pediatrics Asthma Care measure to the State 194. **Milestone:** Report results of the Optimal Diabetes Care Composite to the State 195. **Milestone:** Report results of the Diabetes Composite to the State	196. **Milestone:** Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State 197. **Milestone:** Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State 198. **Milestone:** Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State 199. **Milestone:** Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State 200. **Milestone:** Report results of the Pediatrics Asthma Care measure to the State 201. **Milestone:** Report results of the Optimal Diabetes Care Composite to the State 202. **Milestone:** Report results of the Diabetes Composite to the State

At-Risk Populations Denominator:

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

1. *Antioch Health Center*
2. *Bay Point Health Center*
3. *Brentwood Health Center*
4. *Concord Health Center*
5. *Martinez Health Center*
6. *North Richmond Center for Health*
7. *Pittsburg Health Center*
8. *Richmond 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

Contra Costa Regional Medical Center and Health Centers	DY 6	DY 7 (Amount in $ Millions)	DY 8 (Amount in $ Millions)	DY 9 (Amount in $ Millions)	DY 10 (Amount in $ Millions)
Category 3					
Patient/Care Giver Experience	-	$ 3.775200	$ 5.033600	$ 7.550400	$ 8.808800
Care Coordination	-	$ 3.775200	$ 5.033600	$ 7.550400	$ 8.808800
Preventive Health	-	$ 3.775200	$ 5.033600	$ 7.550400	$ 8.808800
At-Risk Populations	-	$ 3.775200	$ 5.033600	$ 7.550400	$ 8.808800

[i] "The past 12 months" is defined as the prior demonstration year (July 1 – June 30 of the prior year) because:

- This definition allows the DPH system's year-end DSRIP report to build on the 6-month DSRIP report by using the same population in the denominator, which is consistent with the program mechanics and therefore, with how the other categories are being reported.
- The visit/admission/discharge in which the numerator event occurred (e.g., LDL recorded, admission for diabetes complications) will have occurred after the 2 visits to primary care, which is consistent with the reason for defining the population as patients for whom the health system has had sufficient opportunity to provide good care and influence good health.