**SANTA CLARA VALLEY MEDICAL CENTER**

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

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

**APRIL 15, 2011**

**Narrative:**

The purpose of DSRIP Category III is to make “investments in enhancing care delivery for the 5-10 highest burden conditions in public hospitals for the population in question”[[1]](#footnote-2). Measures were selected based on their relevance to public hospital patient populations and for their potential to inform and fuel improvements in population health at these institutions.

The Category III component of the DSRIP Waiver provides the support necessary to build internal institutional capacity to measure and report on metrics within four domains. The domains are as follows: Patient Care Giver Experience, Care Coordination, Preventive Health, and At Risk Populations. SCVMC will report on each measure in accordance with the schedule set forth in the Category III, CA 1115 Waiver – Delivery System Reform Incentive Payments document.

**Domain I: Patient Care Giver Experience**

As expressed in SCVMC’s DSRIP Plan submitted on February, 18, 2011, SCVMC believes that focusing on what patients want in their care is fundamental to improving clinical outcomes, compliance, and quality. The adoption of the CG CAHPS survey and subsequent reporting on the themes identified in the attached matrix (Getting Timely Appointments, Care, and Information; How Well Doctors Communicate with Patients; Helpful, Courteous, and Respectful Office Staff; Patients’ Rating of the Doctor; and Shared Decision Making) will facilitate an increased understanding of the patients experience at SCVMC and will inform our current and future efforts to improve the experiences of our patients.

**Domain 2: Care Coordination**

Each measure in this section is derived from AHRQ’s Prevention Quality Indicators which are “a set of measures that can be used with hospital inpatient discharge data to identify quality of care for Ambulatory Care-Sensitive Conditions. These are conditions for which good outpatient care can potentially prevent the need for hospitalizations, or for which early intervention can prevent complications or more severe disease.”[[2]](#footnote-3) The Ambulatory Sensitive Conditions which will be measured are as follows: Short term complications from Diabetes, Uncontrolled Diabetes, Congestive Heart Failure admissions, and Chronic Obstructive Pulmonary Disease admissions.

**Domain 3: Preventive Health**

The Preventive Health domain will provide information on SCVMC’s use of key screenings and/or referrals that may prevent or minimize key sources of illness in adults and/or children. The measures that SCVMC will assess through this domain are: Mammography screening, Influenza Immunization, Child Weight Screening, Pediatric Body Mass Index, and Tobacco Cessation. Each measure will assess the degree to which these preventive efforts have been successfully spread through our engaged primary care patient population. These measures will also establish a baseline for future improvement efforts.

**Domain 4: At-Risk Population**

This Domain will provide information on the management of medically at risk patients. Data will be collected on the LDL and A1c control of our diabetic population in addition to two composite measures of diabetes management. The 30-day readmission rate for congestive heart failure patients, blood pressure control in hypertensive patients, and a measure on Pediatric Asthma care will also be reported. This data will indicate the current level of control for many of our medically at risk patients and indicate areas where future interventions could be beneficial.

**Connection to other Projects:**

The data that will be collected and reported on through the Category III initiative connects directly to many of our DSRIP initiatives and indirectly to all of them. As indicated in our DSRIP Plan for Categories I, II and IV, a significant number of our patients live with one or more chronic diseases, with diabetes being the most prevalent condition. To meet the growing health needs of chronic disease patients we are in the process of implementing a robust disease management registry (Category I project) as well as expanding the use of the Chronic Care Management Model in our primary care clinics (Category II). Many of the measures in Category III will inform and support these efforts by providing population wide information on the health status of our patients with chronic disease. In addition, we have selected a Patient Experience Project in Category II, which will be informed and enhanced by the data collected through Category III measures.

Overall, Category III facilitates the design and reporting of critical data indicators that will provide information about the health of our patient population over time. A well designed and functional reporting system is an essential tool for positioning public hospitals, like SCVMC, for health care reform in the coming years.

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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** | 1. **Report results of CG CAHPS questions for “Getting Timely Appointments, Care, and Information” theme to the State** 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** | 1. **Report results of CG CAHPS questions for “Getting Timely Appointments, Care, and Information” theme to the State** 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** | 1. **Report results of the Diabetes, short-term complications measure to the State** 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** | 1. **Report results of the Diabetes, short-term complications measure to the State** 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** | 1. **Report results of the Diabetes, short-term complications measure to the State** 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** |

Care Coordination Denominator:

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

1. Valley Health Center Bascom (Pediatrics and OB/GYN Only)
2. Valley Health Center East Valley
3. Valley Health Center Gilroy
4. Valley Health Center Milpitas
5. Valley Health Center Moorpark (Adult Medicine Only)
6. Valley Health Center Sunnyvale
7. Valley Health Center Tully

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).[[3]](#endnote-2)

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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** | 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** 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** | 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** 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** | 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** 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** |

Preventive Health Denominator:

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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** | 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** 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** 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 to the State** 7. **Report results of the Diabetes Composite 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** 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 to the State** 7. **Report results of the Diabetes Composite to the State** |

At-Risk Populations Denominator:

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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 | - | $ 6,327,750 | $ 8,437,000 | $ 12,655,500 | $ 14,764,750 |
| Care Coordination | - | $ 6,327,750 | $ 8,437,000 | $ 12,655,500 | $ 14,764,750 |
| Preventive Health | - | $ 6,327,750 | $ 8,437,000 | $ 12,655,500 | $ 14,764,750 |
| At-Risk Populations | - | $ 6,327,750 | $ 8,437,000 | $ 12,655,500 | $ 14,764,750 |

1. CA 1115 Waiver – Delivery System Reform Incentive Payments (DSRIP). Additional Details on Category 3. By CAPH [↑](#footnote-ref-2)
2. AHRQ Quality Indicators. http://qualityindicators.ahrq.gov/pqi\_overview.htm [↑](#footnote-ref-3)
3. “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. [↑](#endnote-ref-2)