# Appendix A: Category Allocation of Total Computable Payment Amounts

($ in millions)

| | DY-6 | | DY-7 | | DY-8 | | DY-9 | | DY-10 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | $ | % | $ | % | $ | % | $ | % | $ | % |
| **Category 1 Projects (C1):** | | | | | | | | | | |
| 1. Implement and Utilize Disease Management Registry Functionality | 9,833,875 | 50.0% | 7,972,500 | 50.0% | 4,679,500 | 50.0% | 3,741,750 | 50.0% | 1,202,875 | 50.0% |
| 2. Collection of Race, Ethnicity and Language (REAL) Data to Reduce Disparities | 9,833,875 | 50.0% | 7,972,500 | 50.0% | 4,679,500 | 50.0% | 3,741,750 | 50.0% | 1,202,875 | 50.0% |
| ***C1 Total:*** | 19,667,750 | 44.0% | 15,945,000 | 27.6% | 9,359,000 | 15.1% | 7,483,500 | 10.8% | 2,405,750 | 3.5% |
| **Category 2 Projects (C2):** | | | | | | | | | | |
| 3. Implement/Expand Care Transitions Programs | 5,252,250 | 25.0% | 5,048,750 | 25.0% | 4,657,500 | 25.0% | 2,587,500 | 25.0% | - | 0.0% |
| 4. Conduct Medication Management | 5,252,250 | 25.0% | 5,048,750 | 25.0% | 4,657,500 | 25.0% | 2,587,500 | 25.0% | 2,300,000 | 33.3% |
| 5. Expand Medical Homes | 5,252,250 | 25.0% | 5,048,750 | 25.0% | 4,657,500 | 25.0% | 2,587,500 | 25.0% | 2,300,000 | 33.3% |
| 6. Apply Process Improvement Methodology to Improve Quality/Efficiency | 5,252,250 | 25.0% | 5,048,750 | 25.0% | 4,657,500 | 25.0% | 2,587,500 | 25.0% | 2,300,000 | 33.3% |
| ***C2 Total:*** | 21,009,000 | 47.0% | 20,195,000 | 35.0% | 18,630,000 | 30.0% | 10,350,000 | 15.0% | 6,900,000 | 10.0% |
| **Category 3 Domains (C3):** | | | | | | | | | | |
| Domain 1: Patient/Provider Experience | - | - | 3,378,375 | 25.0% | 4,504,500 | 25.0% | 6,756,750 | 25.0% | 7,882,875 | 25.0% |
| Domain 2: Care Coordination | - | - | 3,378,375 | 25.0% | 4,504,500 | 25.0% | 6,756,750 | 25.0% | 7,882,875 | 25.0% |
| Domain 4: Preventive Health | - | - | 3,378,375 | 25.0% | 4,504,500 | 25.0% | 6,756,750 | 25.0% | 7,882,875 | 25.0% |
| Domain 5: At-risk Populations | - | - | 3,378,375 | 25.0% | 4,504,500 | 25.0% | 6,756,750 | 25.0% | 7,882,875 | 25.0% |
| ***C3 Total:*** | - | 0.0% | 13,513,500 | 23.4% | 18,018,000 | 29.0% | 27,027,000 | 39.2% | 31,531,500 | 45.7% |
| **Category 4 Projects (C4):** | | | | | | | | | | |
| 7. Improve Severe Sepsis Detection and Management | 1,164,625 | 28.9% | 2,329,250 | 28.9% | 4,658,500 | 28.9% | 6,987,750 | 28.9% | 8,152,375 | 28.9% |
| 8. Central Line-Associated Bloodstream Infection (CLABSI) Prevention | 952,875 | 23.7% | 1,905,750 | 23.7% | 3,811,500 | 23.7% | 5,717,250 | 23.7% | 6,670,125 | 23.7% |
| 9. Surgical Site Infection (SSI) Prevention | 952,875 | 23.7% | 1,905,750 | 23.7% | 3,811,500 | 23.7% | 5,717,250 | 23.7% | 6,670,125 | 23.7% |
| 10. Hospital-acquired Pressure Ulcer (HAPU) Prevention | 952,875 | 23.7% | 1,905,750 | 23.7% | 3,811,500 | 23.7% | 5,717,250 | 23.7% | 6,670,125 | 23.7% |
| ***C4 Total:*** | 4,023,250 | 9.0% | 8,046,500 | 13.9% | 16,093,000 | 25.9% | 24,139,500 | 35.0% | 28,162,750 | 40.8% |
| ***Total Computable Amount for All Categories*** | 44,700,000 | 100% | 57,700,000 | 100% | 62,100,000 | 100% | 69,000,000 | 100% | 69,000,000 | 100% |

# Appendix B: Category 3 - Population-focused Improvement Reporting Measures

***(Addendum to DSRIP Five-Year Plan Submitted February 18, 2011)***

## *Narrative:*

On February 18, 2011, the University of California, Davis Medical Center submitted a five-year "California Bridge to Reform" Delivery System Reform Incentive Pool (DSRIP) Proposal for the California Section 1115(a) Medicaid Demonstration. This proposal included ten projects to: (1) improve infrastructure development (Projects 1 and 2); (2) provide innovation and redesign of patient care processes (Projects 3-6); and (3) urgently improve four patient care systems implementing well established evidence of care to improve patient safety and patient quality outcomes (Projects 7-10).

With the submission of this *Appendix B* to our overall DSRIP proposal, we are adding four additional projects within the newly approved Category 3 that focuses upon population health measures. The overall goal within these four projects is to build the capacity to report upon our performance in these population health measures. These four additional projects will be implemented during the last four years (DY-7 through DY-10) of the DSRIP.

These projects will be implemented in each of our UCDMC primary care sites using our patient centered medical home definitions for the populations managed in these practices (listed below):

1. UCDMC Internal Medicine Clinics;
2. UCDMC Pediatric Clinics;
3. UCDMC Family and Community Based Clinics; and
4. UCDMC Primary Care Network Sites:
    a. Auburn Bell;
    b. Auburn Professional;
    c. Capital O Street;
    d. Carmichael;
    e. Davis;
    f. Elk Grove;
    g. Folsom;
    h. J Street;
    i. Natomas;
    j. Placer Center for Health;
    k. Rancho Cordova; and
    l. Roseville.

## *Project 11 (Category 3) – Patient / Provider Experience:*

Key to the success of improving the health of a patient population is the patient's perceptions of the experience with that care. They must feel they have timely access to care, can communicate with their care giver, receive respectful treatment, evaluate their own received care as high quality, and finally feel they participate in medical decision making. UCDMC practices will evaluate each of these areas with standardized questions and utilize this data for process improvement.

### *Project 12 (Category 3) - Care Coordination:*

Successful management of chronic illness requires appropriate systems and practices to sustain health and slow or prevent associated complications. UCDMC will measure for its patient centered medical home population the admission rate for diabetes patients due to complications or poor control. We will also measure admission rates for our populations with CHF and COPD. Establishing this data will allow measurement of success of existing coordination of care practices and design/implementation of new practices for disease management.

### *Project 13 (Category 3) - Preventive Health:*

Accountability for a population's health and wellbeing require proactive system-based methods to promote, sustain, and measure outcomes associated with best practice based preventive health interventions. UCDMC will measure it performance over a range of preventive health tactics including mammography screening for breast cancer, immunization rates for appropriate populations, childhood screening for risk and development of obesity, and tobacco use screening and cessation strategies. Trending and tracking will allow changing in performance improvement strategy to increase preventive screening rates.

### *Project 14 (Category 3) - At Risk Populations:*

It is clear that certain populations with chronic and progressive diseases suffer accelerated morbidity which is associated with increased health care utilization and cost, when evidence based best practice interventions are not utilized. UCDMC will track levels and control of low density lipoproteins in diabetes, levels and control of hemoglobin A1c in diabetes, admission and readmission rates in chronic congestive heart failure, control of blood pressure in patients with chronic hypertension, and use of controller meds in persistent childhood asthma. Because diabetes is so such an important chronic disease both in terms of morbidity and cost, UCDMC will track and report both the Minnesota Community Measure for optimal diabetes care composite and the National Committee for Quality Assurance diabetes care composite. Tracking and reporting of these measures will be used to focus performance improvement activities within all of our UCDMC ambulatory practices.

| Project 11 (C3) – Patient / Provider Experience | | | | |
|---|---|---|---|---|
| **Year 1 (DY-6)** | **Year 2 (DY-7)** | **Year 3 (DY-8)** | **Year 4 (DY-9)** | **Year 5 (DY-10)** |
| ***N/A*** | 1. Undertake the necessary planning, redesign, translation, training and contract negotiations in order to implement CG-CAHPS in DY8. | 2. 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.<br>3. 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.<br>4. 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.<br>5. 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.<br>6. 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. | 7. Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme to the State.<br>8. Report results of CG CAHPS questions for "How Well Doctors Communicate With Patients" theme to the State.<br>9. Report results of CG CAHPS questions for "Helpful, Courteous, and Respectful Office Staff" theme to the State.<br>10. Report results of CG CAHPS questions for "Patients' Rating of the Doctor" theme to the State.<br>11. Report results of CG CAHPS questions for "Shared Decisionmaking" theme to the State. | 12. Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme to the State.<br>13. Report results of CG CAHPS questions for "How Well Doctors Communicate With Patients" theme to the State.<br>14. Report results of CG CAHPS questions for "Helpful, Courteous, and Respectful Office Staff" theme to the State.<br>15. Report results of CG CAHPS questions for "Patients' Rating of the Doctor" theme to the State.<br>16. Report results of CG CAHPS questions for "Shared Decisionmaking" theme to the State. |

| Project 12 (C3) – Care Coordination | | | | |
|---|---|---|---|---|
| **Year 1 (DY-6)** | **Year 2 (DY-7)** | **Year 3 (DY-8)** | **Year 4 (DY-9)** | **Year 5 (DY-10)** |
| ***N/A*** | 1. Report results of the Diabetes, short-term complications measure to the State.<br>2. Report results of the Uncontrolled Diabetes measure to the State. | 3. Report results of the Diabetes, short-term complications measure to the State.<br>4. Report results of the Uncontrolled Diabetes measure to the State.<br>5. Report results of the Congestive Heart Failure measure to the State.<br>6. Report results of the Chronic Obstructive Pulmonary Disease measure to the State. | 7. Report results of the Diabetes, short-term complications measure to the State.<br>8. Report results of the Uncontrolled Diabetes measure to the State.<br>9. Report results of the Congestive Heart Failure measure to the State.<br>10. Report results of the Chronic Obstructive Pulmonary Disease measure to the State. | 11. Report results of the Diabetes, short-term complications measure to the State.<br>12. Report results of the Uncontrolled Diabetes measure to the State.<br>13. Report results of the Congestive Heart Failure measure to the State.<br>14. Report results of the Chronic Obstructive Pulmonary Disease measure to the State. |

**Care Coordination Denominator:**

The UC Davis Medical Center primary care clinics are listed on page 36.

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]

| Project 13 (C3) – Preventive Health | | | | |
|---|---|---|---|---|
| **Year 1**<br>**(DY-6)** | **Year 2**<br>**(DY-7)** | **Year 3**<br>**(DY-8)** | **Year 4**<br>**(DY-9)** | **Year 5**<br>**(DY-10)** |
| ***N/A*** | 1. Report results of the Mammography Screening for Breast Cancer measure to the State.<br><br>2. Reports results of the Influenza Immunization measure to the State. | 3. Report results of the Mammography Screening for Breast Cancer measure to the State.<br><br>4. Reports results of the Influenza Immunization measure to the State.<br><br>5. Report results of the Child Weight Screening measure to the State.<br><br>6. Report results of the Pediatrics Body Mass Index (BMI) measure to the State.<br><br>7. Report results of the Tobacco Cessation measure to the State. | 8. Report results of the Mammography Screening for Breast Cancer measure to the State.<br><br>9. Reports results of the Influenza Immunization measure to the State.<br><br>10. Report results of the Child Weight Screening measure to the State.<br><br>11. Report results of the Pediatrics Body Mass Index (BMI) measure to the State.<br><br>12. Report results of the Tobacco Cessation measure to the State. | 13. Report results of the Mammography Screening for Breast Cancer measure to the State.<br><br>14. Reports results of the Influenza Immunization measure to the State.<br><br>15. Report results of the Child Weight Screening measure to the State.<br><br>16. Report results of the Pediatrics Body Mass Index (BMI) measure to the State.<br><br>17. Report results of the Tobacco Cessation measure to the State. |

**Preventive Health Denominator:**

The UC Davis Medical Center primary care clinics are listed on page 36.

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]

| Project 14 (C3) – At-Risk Populations | | | | |
|---|---|---|---|---|
| **Year 1 (DY-6)** | **Year 2 (DY-7)** | **Year 3 (DY-8)** | **Year 4 (DY-9)** | **Year 5 (DY-10)** |
| ***N/A*** | 1. Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State.<br>2. Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State | 3. Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State.<br>4. Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State.<br>5. Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State.<br>6. Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State.<br>7. Report results of the Pediatrics Asthma Care measure to the State.<br>8. Report results of the Optimal Diabetes Care Composite for at least data from the last two quarters of the demonstration year to the State.<br>9. Report results of the Diabetes Composite for at least data from the last two quarters of the demonstration year to the State. | 10. Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State.<br>11. Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State.<br>12. Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State.<br>13. Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State.<br>14. Report results of the Pediatrics Asthma Care measure to the State.<br>15. Report results of the Optimal Diabetes Care Composite to the State.<br>16. Report results of the Diabetes Composite to the State. | 17. Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State.<br>18. Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State.<br>19. Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State.<br>20. Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State.<br>21. Report results of the Pediatrics Asthma Care measure to the State.<br>22. Report results of the Optimal Diabetes Care Composite to the State.<br>23. Report results of the Diabetes Composite to the State. |

**At-Risk Populations Denominator:**

The UC Davis Medical Center primary care clinics are listed on page 36.

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]

[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.