SMMC WAIVER MILESTONES PROPOSAL

Background:

San Mateo Medical Center (SMMC) is a 509-bed public hospital and clinic system fully accredited by The Joint Commission. SMMC's predominant service is a network of outpatient clinics throughout San Mateo County, supported by long-term care facilities in San Mateo and Burlingame and an acute-care hospital that includes both medical and psychiatric inpatient and emergency services. We served 76,297 patients and delivered 238,572 outpatient visits in 2009-10. Our payor mix is 43% Medicaid, 31% Uninsured, 16% Medicare, 8% Commercial/Third Party payors, and 2% Healthy Kids/Healthy Families. The mission of San Mateo Medical Center is to "open doors to excellence in healthcare." As part of the San Mateo County Health System, SMMC serves the health care needs of all residents of San Mateo County, with an emphasis on education and prevention. Our vision is to offer timely access to care through an integrated delivery system, with a culture of service, innovation, satisfaction and safety. The Public Health Division of the San Mateo County Health System operates the Edison Clinic, which is located on the main campus of SMMC. Edison Clinic is the sole Ryan White funded provider of outpatient/ambulatory medical care for HIV-positive residents in San Mateo County and exemplifies one delivery system that is designed to be patient-centered while serving a unique population with a specific health issue in the county. In working toward achieving this vision, SMMC currently has strategically-placed and comprehensive health services upon which to build an integrated approach to care. Despite this intensive work, improvement remains to be made to reach our vision.

Executive Summary:

In this proposal, we:

- **Identify key challenge areas that need to be addressed** in order to provide better care for patients and to transition successfully to health care reform implementation. Specifically, these are the barriers that SMMC feels it must overcome in order to: improve the quality of care we deliver, improve the patient's experience of care, improve population health and reduce the cost of care. Following are descriptions of the high-level challenges. We also provide specific issues within each of these challenges throughout the proposal, including the variables that are being modified and the resulting impact.
    1. There is inadequate primary care capacity to meet demand.
    2. Health care disparities are likely to exist but remain unrecognized and therefore unaddressed.
    3. All patients are not necessarily receiving the right care in the right place at the right time, reflecting poorly coordinated care.
    4. Existing primary care capacity is not necessarily being used in the most effective and efficient manner.

5. Although improving the patient's experience of care is an institutional priority, our ability to improve is impaired by inadequate tools and data.
6. Primary care and mental health function separately.
7. There is inadequate access to specialty care and specialty care capacity is not always efficiently or effectively utilized.
8. Care is not at all times of sufficient value, that is, the highest quality at the lowest cost.
9. Patients seeking care for sepsis suffer high rates of morbidity and mortality.
10. Patients suffer from serious hospital acquired infections related to central lines.
11. Patients may experience serious complications related to surgical site infections.
12. Patients can suffer significant injuries due to falls in the acute care setting.
13. Patients who were previously eligible for Ryan White funded primary medical care for HIV disease may suffer from a lack of coordination and continuity of care in the transition to LIHP.

- **Determine five major categories of delivery system reform to address these challenges** and prepare for health care reform as outlined in the California Section 1115 Waiver Terms and Conditions:
  - Category I: **Infrastructure Development** – Investments in technology, tools and human resources that will strengthen the organization's ability to serve its population and continuously improve its services
  - Category II: **Innovation and Redesign** – Investments in new and innovative models of care delivery (e.g., Medical Homes) that have the potential to make significant, demonstrated improvements in patient experience, cost and disease management
  - Category III: **Population-focused Improvement** - Investments in enhancing care delivery for the highest burden conditions in the populations served by California Public Hospitals (Category III plan to be submitted at a later date)
  - Category IV: **Urgent Improvement in Care** – Broad dissemination of top-level interventions where there is deep evidence that major improvement in care is possible within 5 years, and that are measurable and meaningful for almost all hospital populations such as those served by the California Public Hospitals

- Category V: HIV Transition Projects – Investments enhancing the model of care delivery (e.g., Medical Homes for HIV patient populations), technology to strengthen the organization's ability to serve its population and continuously improve services, and enhancements to ensure the smooth, well-coordinated transition of Ryan White clients to the Low Income Health Program.

- **Establish a five-year implementation plan** of 17 projects and 167 investment, improvement, and outcomes milestones, which commit SMMC to concrete progress on the four major categories of delivery system reform:
  - Investment milestones reflect needed investment in infrastructure, resources, processes, and programs.
  - Improvement milestones demonstrate significant care transformation.
  - Outcomes milestones reflect improved clinical and process outcomes, patient experience, and Emergency Department/hospital utilization rates.
  - Assigned all HIV patients to medical homes with HIV expertise.
  - Improved the infrastructure to enhance data sharing between SMMC and the Department of Public Health to better inform the delivery of patient care and develop strategies for addressing local HIV population needs.
  - Ensured the access of Ryan White wrap-around services for all LIHP enrollees.

At the end of the five years, if we achieve the milestones we are proposing, we will have:

- Reduced the time to third next available appointment to less than seven days in four clinics
- Expanded primary care capacity by adding three new provider teams
- Implemented best practice race, ethnicity, gender, primary language, and literacy (REAL) data for at least 90% of patients seen at SMMC
- Incorporated the comparison of patient demographic and quality data to identify disparities
- Assigned at least 90% of eligible patients to primary care teams
- Reduced no-show rates for medical home patients to less than 10%
- Spread validated patient experience surveys to the outpatient and Emergency Department settings
- Made patient experience data for the medical/surgical wards, Emergency Department, and four outpatient clinics easily available to staff
- Implemented physical-behavioral health care integration in at least four primary care clinics
- Utilized depression screening tools for at least 60% of patients with diabetes
- Implemented an electronic "SMART" referral system to improve efficiency and expand specialist capacity, such that 90% of referrals are submitted through the system and 70% of patients are evaluated in less than 30 days
- Completed at least 12 efficiency and quality improvement initiatives using LEAN methodologies and trained at least 15 medical providers and thirty other staff in their use
- Improved compliance with a validated set of interventions to reduce sepsis mortality
- Reduced central line associated bloodstream infections
- Reduced surgical site infections
- Achieved a rate of zero falls with injury per 1000 patient days for at least six months of the year

The proposal is structured so that each section articulates the key challenges, our innovative solutions based on proven methods to address the challenges, and the five-year milestones we commit to meeting in implementing the solutions. The solutions represent outcomes for our patients and our delivery system. This proposal identifies the challenges, the variables being modified, the modifications to those variables, and the expected outcomes. All of the milestones are measurable.

Category 1: Per the California Section 1115 Waiver Terms and Conditions, the purpose of Category 1: Infrastructure Development is "investments in technology, tools and human resources that will strengthen the organization's ability to serve its population and continuously improve its services." Therefore, San Mateo Medical Center's Category 1 plan includes infrastructure development, including investment in people, places, processes and technology. This category is foundational to the success of Categories 2-4. This plan describes how the Category 1 infrastructure development will enhance capacity to conduct measure, and report on quality/performance improvement, expand access to meet demand, and enable improved care with strong emphasis on building coordinated systems that promote preventive, primary care.

Key Challenge: There is inadequate primary care capacity to meet current demand:

- *Our primary care capacity is only able to serve about 53,000 patients annually while the San Mateo County Health System currently estimates demand at 90,000 patients:* Primary care capacity, resources, infrastructure, and technology are severely limited.

Major Delivery System Solutions:

- *Increasing Primary Care Capacity:* In order to provide more preventive, primary, and chronic care in the primary care setting, it is critical to expand primary care capacity. Our goal is to better treat the volume of patients who need primary care in the primary care setting, with limited wait times. In order to provide more preventive, primary, and chronic care in the primary care setting, it is critical to expand primary care capacity. This includes increased efficiencies to maximize the capacity San Mateo Medical Center already has, as well as adding capacity so that we can treat more patients. In order to do this, we propose to:
    - Expand Primary Care Capacity; and
    - Re-Integrate Urgent Care Services into Primary Care Clinics in order to significantly reduce the need for a dedicated same day provider to see urgent care patients; primary care teams will be able to see their own patients with urgent care needs. Enhanced capacity for each primary care team to see its own patients with urgent and ongoing needs enhances care continuity.

- *Expected Result:* At least three new primary care providers will have been hired. At least four primary care clinics will have implemented new systems such that empanelled patients can see their primary care team within 7 days. These gains will occur as a result of expanding primary care capacity, including the reintegration of urgent care services into primary care.

Relation to Improvements addressed in other projects: Expanded primary care capacity also feeds into the expansion of medical homes and more organized care delivery, better prevention and management of chronic conditions, integrated physical-behavioral health care, and better utilization of health care resources. With expanded primary care capacity, more patients can have access to primary and preventive care, which increases opportunities to prevent disease and treat it early. Inpatients and Emergency Department patients, upon discharge, can be scheduled for follow-up appointments and care at a primary care clinic, thereby reducing the risk and consequences of worsening health conditions.

Implementation Milestones

We will receive funding after meeting the following milestones in this project:

	Expanding Primary Care Capacity					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Related Projects**
Expanding Primary Care Capacity	1. Milestone: Initiate position creation for at least one additional primary care provider position to establish at least one additional primary care team in one clinic Metric: Document initiation of position creation	2. Milestone: Implement a system to accommodate urgent care needs in at least 1 primary care clinic, as measured by achieving Time to Third Next Available Appointment of under 7 days for empanelled patients for at least 3 months during year. Metric: Third-Next-Available Appointment Available Within seven calendar days: Number of Calendar days until third next available appointment.[1] The rate is an average, measured monthly, for all providers within clinic	3. Milestone: Hire at least one additional primary care provider to establish at least one additional primary care team in one clinic (total of two care teams across system compared with baseline). Metric: Hiring of staff 4. Milestone: Implement a system to accommodate urgent care needs in at least 1 additional (2 total) primary care clinic, as measured by achieving Time to Third Next Available Appointment of under 7 days for empanelled patients (for at least 3 months during year) in at least 2 clinics within the system. Metric: Third-Next-Available Appointment Available Within 7 Calendar Days: Number of Calendar days until third next available appointment	5. Milestone: Hire at least 1 additional primary care provider to establish at least one additional primary care team in one clinic (total of three care teams across system compared with baseline). Metric: Hiring of staff 6. Milestone: Implement a system to accommodate urgent care needs in at least 1 additional (3 total) primary care clinic as measured by achieving Time to Third Next Available Appointment of under 7 days for empanelled patients (for at least 3 months during year) in at least 3 clinics within system. Metric: Third-Next-Available Appointment Available Within 7 Calendar Days: Number of Calendar days until third next available appointment	7. Milestone: Implement a system to accommodate urgent care needs in at least 1 additional (4 total) primary care clinic as measured by achieving Time to Third Next Available Appointment of under 7 days for empanelled patients (for at least 3 months during year) within at least 4 clinics within system. Metric: Third-Next-Available Appointment Available Within 7 Calendar Days: Number of Calendar days until third next available appointment)	• Spreading primary care medical homes (Cat. 2) • Redesigning Primary Care (Cat. 2) • Improving care coordination (Cat. 3) • Improving Patient/ Caregiver Experience(Cat. 2 and 3) • Improving preventive health screening (Cat. 3) • Improve the care of at-risk populations (Cat. 3)

[1] Taken from IHI definition in white paper on whole system measures

Key Challenge: Health Care Disparities are likely to exist but remain unrecognized and therefore unaddressed

SMMC patients are diverse and multi-lingual. Of our patients, 58.5% are Hispanic/Latino, 14.7% are White, 4.9% are Black, 9.3% are Asian, and 12.6% Other. In order to make sure patients are sufficiently engaged in their care, we need to break down barriers that result from health care disparities. By doing so, we will improve communication between the patient and the provider, patients will be more involved in their health care, and patients will receive equitable health care.

Major Delivery System Solutions:

Collection of Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities: While San Mateo Medical Center may presume that health care disparities exist, we are an enterprise that believes in using data to drive quality improvement. Therefore, we believe it is imperative to stratify quality data, such as clinical outcomes and interventions, by race, ethnicity and language ("REAL data") so that we know the facts of where disparities exist. By having this knowledge, we will be able to target improvements in health care equity appropriately and effectively, and measure our progress along the way. Providing equitable care is critical to getting patients engaged in their care – every patient, regardless of who they are, deserves high quality health care. It is likely that race, ethnicity and language disparities exist both in accessing and receiving care; however, we have unreliable data by which to identify them. Therefore, it is our goal to develop the ability to: (1) Collect patient demographic data in a way that can be compared to quality and health outcomes data and (2) Stratify patient demographic data by outcomes to identify disparities.

Expected Result: REAL Data is available to identify disparities for at least 90% of patients seen (encountered) throughout the organization

Relation to improvements addressed in other projects: Reducing disparities in health care will support improved care for all projects in all categories through the provision of equitable health care. The identification of disparities is especially important for optimizing care for at-risk populations.

Implementation Milestones

We will receive funding after meeting the following milestones in this project:

	Collection of Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Related Projects**
Collection of Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities	8. **Milestone:** Develop a plan to improve collection of patient demographic information such as race, ethnicity, gender, primary language, and literacy level ("REAL data") in order to identify potential health care disparities **Metric:** Documentation of plan, including work plan and timelines.	9. **Milestone:** Establish data stratification and comparison processes for capturing accurate REAL data and linking it to quality data, including designating specified data fields for REAL data recording **Metric:** Documentation of established processes, including work plan and timelines.	10. **Milestone:** At least 70% of unique patients seen within the reporting period have the designated REAL data fields recorded as structured data **Metric:** The percent of patients with Race, Ethnicity and Language (REAL) fields identified in Health Information Systems • **Numerator:** Number of unique patients seen within the reporting period who have the designated REAL data fields recorded • **Denominator:** Number of total unique patients seen within the reporting period	11. **Milestone:** At least 80% of unique patients seen within the reporting period have the designated REAL data fields recorded as structured data **Metric:** The percent of patients with Race, Ethnicity and Language (REAL) fields identified in the Health Information Systems • **Numerator:** Number of unique patients seen within the reporting period who have the designated REAL data fields recorded • **Denominator:** Number of total unique patients seen within the reporting period	12. **Milestone:** At least 90% of unique patients seen within the reporting period have the designated REAL data fields recorded as structured data **Metric:** The percent of patients with Race, Ethnicity and Language (REAL) fields identified in Health Information Systems • **Numerator:** Number of unique patients seen within the reporting period who have the designated REAL data fields recorded • **Denominator:** Number of total unique patients seen within the reporting period 13. **Milestone:** Perform REAL data analysis and identify at least two specific health care disparities **Metric:** Report of the results of the analysis with identification of two specific health care disparities	• Spreading primary care medical homes (Cat. 2) • Redesigning Primary Care (Cat. 2) • Improving care coordination (Cat. 3) • Improving Patient/ Caregiver Experience(Cat . 2 and 3) • Improving preventive health screening (Cat. 3) • Improve the care of at-risk populations (Cat. 3)

Category 2: Per the Waiver Terms and Conditions, the purpose of Category 2: Innovation and Redesign is "investments in new and innovative models of care delivery (e.g., Medical Homes) that have the potential to make significant, demonstrated improvements in patient experience, cost and disease management." Therefore, San Mateo Medical Center's Category 2 projects include the piloting, testing, and spreading of innovative care models. San Mateo Medical Center's patient population experiences significant challenges associated with poverty, such as psychosocial barriers to health and multiple concurrent medical conditions. San Mateo Medical Center has had to be very creative to address the needs of the patient population with extremely limited resources. SMMC needs to further refine these innovations, test new ways of meeting the needs of our target populations, and disseminate learnings in order to spread promising practices.

Key Challenge: All patients are not necessarily receiving the right care in the right place at the right time, reflecting poorly coordinated care.

- *Some potential medical home patients do not have an assigned primary care provider: One of the prerequisites for a medical home is that a patient must have a primary care provider team that they can identify and trust.* SMMC has piloted the medical home and chronic care models, but needs to spread these effective models throughout the hospital system. Right now, some primary care clinics are utilizing some components of these models, but not necessarily all. For example, while most clinics make some attempt to empanel patients, there is variation in the rigor of this process and inconsistency in commitment to scheduling patients with their designated care team. We want to make sure these models are embedded within our care delivery model.
- *Only about 61% of our providers are organized as care teams, while the remaining 29% are still functioning in a more traditional approach.*
- *Only 20,000 of our patients are assigned to primary care teams*, thereby missing opportunities to provide better care through improved prevention screenings and routine primary and chronic care.

Major Delivery System Solutions:

- *Spreading Primary Care Medical Homes:* To address this challenge, we have already begun work to make sure that all patients will receive the right care in the right place at the right time. This is a strategic priority for SMMC because by providing more patients with coordinated care services grounded in their primary care medical homes, patients can stay healthier and manage their chronic conditions, thereby reducing avoidable ED visits, admissions, and readmissions. Patients will receive this care in a proactive, planned manner so that they can receive evidence-based interventions.

It is a strategic priority of SMMC to provide a continuity of primary care for our patients through the medical home model. We have begun to offer primary care medical homes to patients so that preventive, primary, and chronic care can be managed proactively in the outpatient setting, thereby keeping patients healthy and out of the hospital. In 2007, SMMC opened its Innovative Primary Care Clinic, which piloted many components of what we believe should be spread and sustained throughout our primary care clinics. This initiative included comprehensive clinic redesign through which we implemented:

- Medical home team-based care
- Expanded staff roles
- The Chronic Care Model, including initiating a disease registry to track patients with chronic conditions and thereby proactively manage their care
- Advanced patient access to appointments
- Performance outcomes measurement
- Effective use of health information technology (IT
- Coordination of care with support staff
- Health promotion and education

Staff includes nutritionists, social workers, community health workers and therapists. Services include group visits, case management, and telephone outreach. We also have implemented a medication management program with a clinic-based pharmacist at the Innovative Care Clinic.
The Innovative Care Clinic utilizes the Chronic Care Model to enhance primary and preventive care delivery with appropriate management of chronic conditions. This chronic disease management and care coordination includes the identification and management of patients with complex and/or combinations of chronic diseases and improved management of chronic disease across systems to enhance efficiency and effectiveness in care coordination and utilization of medical resources. As a result of this improved care, blood sugar, blood pressure and cholesterol levels have been reduced for patients regularly treated by the Innovative Care Clinic.

By spreading this model beyond the Innovative Care Clinic to all of our primary care clinics comprehensively and systemically, we will make a real difference in the experience, outcomes and cost of health care. Please see Appendix A for more specific results of piloting the medical home model in the Innovative Care Clinic.

Primary care medical homes need to be spread and sustained system-wide. In order to achieve this, we need to increase our capacity for expanded primary care services. We propose to implement this model fully in all of our primary care clinics so that San Mateo County patients receive more preventive, primary, and chronic care. Our patients will have a care team and a care plan so that they can experience a continuity of care and establish trusting relationships with their care teams. They will have more access to primary care so that they can get the care when they need it. This will enable patients to receive the right care in the right place at the right time.

- *Expected Result:* <u>At least 90% of eligible patients are assigned to primary care teams serving as their medical homes.</u> Care teams actively manage their patient panel so that patients are reminded of services needed and receive coordinated care rooted in a primary care setting. Patients know the professionals on their care team and establish trusting, ongoing relationships to reinforce continuity of care.

- *Relation to improvements in other categories:* By spreading the medical home model to all of our primary care clinics to empanel tens of thousands of patients comprehensively and systemically, we will make a real difference in the experience, results and cost of health care.

Implementation Milestones

We will receive funding after meeting the following milestones in this project:

	Spreading Primary Care Medical Homes					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Related Projects**
Spreading Primary Care Medical Homes	14. **Milestone:** Establish process to track assignment of patients to primary care provider teams **Metric:** Documentation of process and production of panel reports (patients assigned to individual primary care provider teams**)**	15. **Milestone:** At least 60% of eligible patients will be assigned to primary care provider teams **Metric:** primary care provider team assignment • **Numerator:** Number of eligible patients assigned to a primary care provider • **Denominator:** Number of eligible patients (patients seen at the same primary care clinic at least twice in last 12 months)	16. **Milestone:** At least 70% of eligible patients will be assigned to primary care provider teams **Metric:** Primary Care Provider Team Assignment • **Numerator:** Number of eligible patients assigned to a primary care provider • **Denominator:** Number of eligible patients (patients seen at the same primary care clinic at least twice in last 12 months	17. **Milestone:** At least 75% of eligible patients will be assigned to primary care provider teams **Metric:** Primary Care Provider Team Assignment • **Numerator:** Number of eligible patients assigned to a primary care provider • **Denominator:** Number of eligible patients (patients seen at the same primary care clinic at least twice in last 12 months	18. **Milestone:** At least 90% of eligible patients will be assigned to primary care provider teams **Metric:** Primary Care Provider Team Assignment • **Numerator:** Number of eligible patients assigned to a primary care provider • **Denominator:** Number of eligible patients (patients seen at the same primary care clinic at least twice in last 12 months) 19. **Milestone:** Report shared learnings of the medical home model, and any findings related to impact on improved health, experience and cost to the Safety Net Institute and SMMC Stakeholders **Metric**: Report Production	• Redesigning Primary Care (Cat. 2) • Improving care coordination (Cat. 3) • Improving Patient/ Caregiver Experience(Cat. 2 and 3) • Improving preventive health screening (Cat. 3) • Improve the care of at-risk populations (Cat. 3)

Key Challenge: Existing Primary Care Capacity is not necessarily being used in the most effective and efficient manner:

We currently have about 2,200 patients waiting for primary care medical home appointments. It may be difficult for the patient to get a primary care appointment in a timely manner due to traditional scheduling processes and the practice of medicine structured around the physician, not around the patient.

Major Delivery System Solutions:

- *Primary Care Redesign:* In order to address this challenge, San Mateo Medical Center will redesign primary care to achieve increased efficiencies to maximize the capacity we already have. This plan seeks to build upon work we have started to standardize clinic-level data across San Mateo Medical Center so that we can better understand cycle time, wait times for primary care, and patient satisfaction. In order to do this, we propose to: (1) Build internal capacity with the resources we already have through implemented efficiencies that will reduce primary care cycle times, patient no-show rates, and days to third next available appointments; and (2) Implement the Patient Centered Scheduling Model so that patients can see their primary care team when needed and at the patient's convenience to enable expanded access to primary care. Historically at San Mateo Medical Center, patient appointment "no-show" rates have been as high as 30%.

- *Expected Result:* Patient "no-show" to appointment rate is less than 10% as a result of improved access when it is convenient for the patient and due to establishing an ongoing relationship with his/her care team that reinforces continuity of care.

- *Relation to improvements in other categories:* With increased access to primary care, patients are better able to receive preventive, primary and ongoing care, developing continuity of care with their primary care team. In addition, increased access to primary care and a strong relationship with an established primary care provider improve the patient's experience of care.

Implementation Milestones

We will receive funding after meeting the following milestones in this project:

	Primary Care Redesign					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Related Projects**

	Primary Care Redesign					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Related Projects**
Primary Care Redesign	20. **Milestone**: Establish Patient Centered Scheduling within at least 4 primary care clinics **Metric**: Documentation of the number of clinics that have implemented the core processes of patient centered scheduling including open access appointments and preregistration 21. **Milestone**: Achieve at least a 25% or lower patient no-show rate (for at least 4 months of the reporting period) for primary care medical homes[2] due to enhanced continuity of care and lasting relationships established between the provider and the patient **Metric**: No-show rate **Numerator:** Number of patients who missed an appointment in a medical home session **Denominator**: Number of patients scheduled for each session	22. **Milestone:** Achieve at least a 15% or lower patient no-show rate(for at least 4 months of the reporting period) for primary care medical homes due to enhanced continuity of care and lasting relationships established between the provider and the patient **Metric:** No-show rate • **Numerator:** Number of patients who missed an appointment in a medical home session • **Denominator:** Number of patients scheduled for each session	23. **Milestone:** Achieve at least a 12% or lower patient no-show rate (for at least 4 months of the reporting period) for primary care medical homes **Metric:** No-show rate • **Numerator:** Number of patients who missed an appointment in a medical home session • **Denominator:** Number of patients scheduled for each session	24. **Milestone:** Achieve at least a 10% or lower patient no-show rate (for at least 4 months of the reporting period) for primary care medical homes **Metric:** No-show rate • **Numerator:** Number of patients who missed an appointment in a medical home session • **Denominator:** Number of patients scheduled for each session	25. **Milestone:** Maintain 10% or lower patient no-show rate for primary care medical homes in order to demonstrate sustainability of the improvement for at least 2 consecutive quarters during the reporting period **Metric:** No-show rate • **Numerator:** Number of patients who missed an appointment in a medical home session • **Denominator:** Number of patients scheduled for each session	• Spreading primary care medical homes (Cat. 2) • Improving care coordination (Cat. 3) • Improving Patient/ Caregiver Experience(Cat. 2 and 3) • Improving preventive health screening (Cat. 3) • Improve the care of at-risk populations (Cat. 3)

[2] For this and other milestones using this measure, measurement is determined based on the percentage of the patients scheduled for each session who did not show up for their medical home visit. The rate is an average measured monthly. This measurement would be based on the most recent reporting month.

Key Challenge: Although improving the patient's experience of care is an institutional priority, our ability to improve is impaired by inadequate tools and data

San Mateo Medical Center's commitment to improving the patient's experience of care is embedded in its overall strategic plan. Some areas such as the medical/surgical ward utilize well validated patient surveys from Press Ganey. Other units such as the Emergency Department and outpatient clinics use homegrown survey tools that make it difficult to compare and improve performance.

Major Delivery System Solutions:

- *Redesign to Improve Patient Experience*: We intend to increase the organization's capacity to improve patients' experience of care and their satisfaction with the care provided. This will be accomplished by implementing new tools to measure the patients' experience and satisfaction. In addition, internal display and sharing of data will give staff the tools and information necessary to improve the experience.

- *Expected Results:* Press Ganey survey tools will be spread to the Emergency Department and outpatient clinics. Baseline performance will be measured in the Emergency Department and at least three adult primary care clinics and three pediatric clinics. Performance data from the medical/surgical ward, the Emergency Department and four outpatient clinics will be internally displayed in order to promote performance improvement.

- *Relation to improvements in other categories:* Improved patient experience of care improves our ability to better prevent and manage chronic conditions in partnership with our patients. With improved patient experience, our patients likely have better access to care and are better able to be engaged in and take shared responsibility with staff and providers for managing chronic conditions and improving chronic disease outcomes.

Implementation Milestones

We will receive funding after meeting the following milestones in this project:

	Redesign to Improve Patient Experience					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Related Projects**
Redesign to Improve Patient Experience	26. **Milestone:** Expand the use of Press Ganey Patient Satisfaction surveys into the ambulatory and ED settings **Metric:** Press Ganey Contract /Statement of Work to expand use of survey	27. **Milestone:** Establish baseline performance in Emergency Department. **Metric:** Report Baseline Data 28. **Milestone:** Internally display quarterly patient experience data for inpatient medical/surgical unit **Metric:** Documentation of data display and dissemination	29. **Milestone:** Establish baseline performance in at least one adult outpatient clinic and one pediatric clinic **Metric:** Report Baseline Data 30. **Milestone:** Internally display quarterly patient experience data for Emergency Department **Metric:** Documentation of data display and dissemination	31. **Milestone:** Establish baseline performance in at least one additional adult outpatient clinic and at least one additional pediatric clinic (total of four clinics) **Metric:** Report Baseline Data 32. **Milestone: :** Internally display quarterly patient experience data for at least one adult outpatient clinic and one pediatric clinic **Metric:** Documentation of data display and dissemination	33. **Milestone:** Establish baseline performance in at least one additional adult outpatient clinic and at least one additional pediatric clinic (total of six clinics) **Metric:** Report Baseline Data 34. **Milestone**: Internally display quarterly patient experience data for at least two adult outpatient clinics and two pediatric clinics (total of four clinics) **Metric:** Documentation of data display and dissemination	• All projects (Cat. 1-4)

Key Challenge: Primary Care and Mental Health Function Separately:

- Based on 14% of the more than 5,000 patients we serve in our primary care medical homes with diabetes also suffer from depression.
- The Health System has separate divisions and separate sets of guidelines for behavioral health and primary care, as evidenced by our patients with diabetes who also suffer from depression whose conditions are being treated for these inter-related conditions in discrete institutions.
- For the most part, physical and behavioral health are viewed as neither related nor interdependent.

Major Delivery System Solutions:

- *Integration of Physical and Behavioral Health:* Better integration between primary and behavioral health care will help to more appropriately address these patients' health care needs. As a result, behavioral health conditions can be better diagnosed in primary care settings, medication errors can be reduced, improvements can be made in patients' health outcomes, and utilization of avoidable emergency/inpatient services can be reduced. The Behavioral Health/Primary Care Four Quadrant integration model describes how we should serve the populations that Behavioral Health/Primary Care integration must address: 1) Low behavioral health-low physical health complexity/risk served in primary care with behavioral health staff on site; 2) High behavioral health-low physical health complexity/risk served in a specialty behavioral health system that coordinates with the primary care team; 3) Low behavioral health-high physical health complexity/risk served in the primary care/medical specialty system with behavioral health staff on site in primary or medical specialty care, coordinating with all medical care providers; 4) High behavioral health-high physical health complexity/risk served in both the specialty behavioral health and primary care/medical specialty systems.

- *Expected Result:* Utilizing the Four Quadrant Model, pilots of physical and behavioral health integration will be established in 4 primary care clinics. At least 60% of diabetics will be routinely screened for depression utilizing a standard, evidence based tool.

- *Relation to improvements in other categories:* Recent studies show that integration of behavioral health (mental health and substance abuse) and physical health services should be the standard for advanced health care systems. This finding is part of a larger trend to better integrate the various parts of a health care system in the interest of more cost-effective and comprehensive patient care. The more integrated these various components are *at the programmatic and clinical levels, the* more likely that patients with complex conditions and socio-economic challenges will have their medical and psychosocial needs met in a

comprehensive fashion rather than falling through the cracks between various "silos," with resultant adverse health outcomes and increased cost. There is sufficient evidence that there are significant numbers of patients who could benefit from better recognition and t*reatment of mental health issues within prima*ry care. Health care systems which have successfully implemented programs to integrate behavioral health and primary care services have tended to demonstrate improved care and significant cost savings (Health Management Associates, 2007), in addition to increased provider satisfaction and improved patient satisfaction. A number of leading organizations, including the Institute of Medicine, the Robert *Wood Johnson Foundation, and the Health Reso*urces and Services Administration (HRSA), have either recommended integration of physical and behavioral health services or funded projects dedicated to doing so (Health Management Associates, 2007). Optimal management of chronic diseases such as diabetes is often hampered by unrecognized or inadequately treated depression. In addition, improved recognition of depression through systematic screening within the diabetic population will promote better outcomes. The PHQ-9 is recommended as an effective measurement tool; however, there are other effective tools. Research indicates that 10-15% of all primary care patients have depression, and is one of the top five most common conditions found in primary care settings. According to an evaluation of 20 studies over the past 10 years, the prevalence rate of diabetics with major depression is three to four times greater than in the general population, according to the American Diabetic Association.

Implementation Milestones

We will receive funding after meeting the following milestones in this project:

	Integration of Physical and Behavioral Health					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Related Projects**
Integration of Physical and Behavioral Health	35. **Milestone:** Pilot the Four Quadrant Model through the use of SBIRT (substance abuse Screening, Brief Intervention, Referral, and Treatment)in one primary care clinic **Metric:** Documentation of SBIRT integration in one primary care clinic.	36. **Milestone:** Implement at least 1 pilot of physical and behavioral health integration consistent with the Four Quadrant model **Metric:** Successful implementation of model)	37. **Milestone:** Implement at least one additional pilot (total 2 pilots) of physical and behavioral health integration consistent with the Four Quadrant model **Metric:** Expansion of model to two clinics 38. **Milestone:** Integrate Depression screening of diabetics by using the Patient Health Questionnaire (PHQ-9) (or other validated tool) in the physical and behavioral health integration pilot primary care clinics **Metric:** Percentage of diabetics in pilot clinics who have undergone screening	39. **Milestone:** Implement at least one additional pilot (total 3 pilots) of physical and behavioral health integration consistent with the Four Quadrant model **Metric:** Expansion of model to three clinics 40. **Milestone:** At least 50% of diabetic patients seen in the physical and behavior health integration pilot primary care clinics are screened with the PHQ-9 (or other validated tool) **Metric:** Percentage of diabetics in pilot clinics who have undergone screening	41. **Milestone:** Implement at least one additional pilot (total 4 pilots) of physical and behavioral health integration consistent with the Four Quadrant model **Metric:** Expansion of model to four clinics 42. **Milestone:** At least 60% of diabetic patients seen in the physical and behavior health integration pilot primary care clinics are screened with the PHQ-9 (or other validated tool) **Metric:** Percentage of diabetics in pilot clinics who have undergone screening	• Spreading primary care medical homes (Cat. 2) • Redesigning Primary Care (Cat. 2) • Improving care coordination (Cat. 3) • Improving Patient/ Caregiver Experience(Cat. 2 and 3) • Improving preventive health screening (Cat. 3) • Improve the care of at-risk populations (Cat. 3)

Key Challenge: There is inadequate access to specialty care and specialty care capacity is not always efficiently or effectively utilized:

Specialty care access is a major challenge for SMMC: Wait times for six specialties are greater than 3 months with two specialties having wait times over four months. The referral process can be confusing and inefficient. Its limitations include: lackluster tracking of referrals and outcomes, limited standardization, extensive paper-based rework by staff, inadequate information for specialists and lack of specialty feedback to referring providers. For patients, the referral process is long and cumbersome.

Major Delivery System Solutions:

- *Electronic Specialty Referral Process:* We propose to implement electronic referrals (e-referrals) technology and processes that enable improved and more streamlined provider communications. This e-referrals technology has been successfully implemented in other California public hospitals and other safety net systems. It has been shown to drastically reduce wait times, as well put in place many efficiencies, resulting in increased patient access to specialty care. E-referrals technology will help identify those patients who can be treated in the primary care setting, thereby reducing the volume of patients waiting for and enabling quicker time to treatment by specialists. Specialists will have the information they need to work up patients, while referring providers have the information to continue care delivery. For those patients needing specialty care, this solution will help to make sure that before the specialty visit; all pre-work (e.g., labs, tests, etc.) is completed in the primary care setting so that the specialist can focus on the treatment, thereby eliminating unnecessary specialist time doing such pre-work and increasing efficiency. San Mateo Medical Center's e-referral system will evolve into a "SMART" referral system with embedded clinical guidelines and capacity for bidirectional communication between the primary care provider and the specialist. Through these types of reforms, patient wait times for specialty care appointments can be reduced, waste and inefficiencies can be eliminated, and specialist capacity can be increased. Most importantly, patients can receive more timely interventions**.**

- *Expected Result:* 90% of specialty referrals will be submitted utilizing an electronic referral system that has functionality for bidirectional communication. 70% of referred patients will be evaluated (either in person or electronically) within 30 days of referral.

- *Relation to improvements in other categories:* According to a recent University of California at San Francisco (UCSF) report[3], access to specialists is a common barrier for primary care clinicians trying to deliver high-quality, coordinated care, especially when their patients are poor or uninsured. To offer the standard of care required by the patient-centered medical home model, clinicians must be able to tap into a "medical neighborhood" of specialists and hospitals to obtain timely consultations, diagnostic services, and needed treatments. The way many healthcare networks still communicate is through telephone, paper and fax, which creates process inefficiencies, inaccurate data and slow information updates. Use of electronic referral systems can successfully address many of these issues and improve care outcomes. In addition, more timely access to specialty evaluation and recommendations can improve the patient's experience of care.

[3] See *A Safety-Net System Gains Efficiencies Through 'eReferrals' To Specialists* report. Alice Hm Chen, Margot B. Kushel, Kevin Grumbach, and Hal F. Yee, Jr. http://content.healthaffairs.org/cgi/content/extract/29/5/969

Implementation Milestones

We will receive funding after meeting the following milestones in this project:

	Electronic Specialty Referral Process					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Related Projects**
Electronic Specialty Referral Process	43. **Milestone:** Implement an electronic referral system to enable improved and more streamlined provider communications **Metric:** Documentation of implementation of e-referrals	44. **Milestone:** Expand e-referrals to include bidirectional communication such that 50% of specialty referrals originating from a SMMC primary care provider will be made utilizing bidirectional electronic referral systems **Metric:** o Numerator: Number of referrals made into specialty clinics utilizing electronic referral system o Denominator: Total number of referrals from SMMC primary care providers into specialty clinics 45. **Milestone:** Utilize electronic referral to measure the wait time for specialty care **Metric:** o Numerator: Number of referred patients who are evaluated (electronically or in person) within 30 days o Denominator: Total number of referred patients	46. **Milestone:** 60% of specialty referrals originating from a SMMC primary care provider will be made utilizing bidirectional electronic referral systems **Metric:** o Numerator: Number of referrals made into specialty clinics utilizing electronic referral system o Denominator: Total number of referrals from SMMC primary care providers into specialty clinics 47. **Milestone:** 50% of referred patients will be evaluated (electronically or in person) within 30 days **Metric:** o Numerator: Number of referred patients who are evaluated (electronically or in person) within 30 days o Denominator: Total number of referred patients	48. **Milestone:** 75% of specialty referrals originating from a SMMC primary care provider will be made utilizing bidirectional electronic referral systems **Metric:** o Numerator: Number of referrals made into specialty clinics utilizing electronic referral system o Denominator: Total number of referrals from SMMC primary care providers into specialty clinics 49. **Milestone:** 60% of referred patients will be evaluated (electronically or in person) within 30 days **Metric:** o Numerator: Number of referred patients who are evaluated (electronically or in person) within 30 days o Denominator: Total number of referred patients	50. **Milestone:** 90% of specialty referrals originating from a SMMC primary care provider will be made utilizing bidirectional electronic referral systems **Metric:** o Numerator: Number of referrals made into specialty clinics utilizing electronic referral system o Denominator: Total number of referrals from SMMC primary care providers into specialty clinics 51. **Milestone:** 70% of referred patients will be evaluated (electronically or in person) within 30 days **Metric:** o Numerator: Number of referred patients who are evaluated (electronically or in person) within 30 days o Denominator: Total number of referred patients	• Redesigning Primary Care (Cat. 2) • Improving care coordination (Cat. 3) • Improving Patient/ Caregiver Experience(Cat. 2 and 3) • Improve the care of at-risk populations (Cat. 3)

Key Challenge: Care is not at all times of sufficient value, that is, the highest quality at the lowest cost.

Higher quality, better value care is needed in order to improve patient health outcomes and bend the health care cost curve. In order to address this need, organizations will need to adopt tools and methodologies that will facilitate rapid improvement.

Major Delivery System Solutions:

- *Utilize LEAN management principles and methodologies to rapidly improve and provide efficient, value-added care:* Developed by Toyota in the 1950s to strengthen automobile manufacturing infrastructure and maximize resources, LEAN is an example of a management engineering approach now being adopted successfully by health care organizations to address a range of quality and operational issues. The LEAN method, specifically, provides a range of techniques to create a more efficient and effective workplace by having smooth work flows and eliminating waste in time, effort, or resources. According to the California HealthCare Foundation report "Operations Improvement Methods: Choosing a Path for Hospitals and Clinics" by David Belson, PhD, "LEAN helps providers work toward a state of continuous improvement, whereby the product flows at the pull of the customer in pursuit of perfection." [4] Also, Denver Health System has had much success implementing LEAN process improvement methodologies.[5] We will be implementing 12 LEAN performance improvement events over the five years of this proposal. Lean includes reducing waste so that all work adds value and serves the patient's needs. This work includes identifying value-added and non-value-added activities, fostering an organizational culture with a commitment to continuous quality improvement, and involving all relevant staff in helping to redesign processes to improve flow and reduce waste.

- *Expected Result:* Complete 12 LEAN Process Improvement Events. Train Executive Management and at least 15 medical providers and 30 additional staff members as process improvement champions with expertise in LEAN methodologies.

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[4] See: http://www.chcf.org/publications/2007/12/improving-efficiency-management-engineering-comes-to-the-safety-net#ixzz11umwfMFJ

[5] Meyer, Harris, "Life in the 'Lean' Lane: Performance Improvement at Denver Health," *Health Affairs* (November 2010), vol. 29 no. 11, 2054-2060

- *Relation to Category 3 Population-Focused Improvement and Category 4 Urgent Improvements in Quality and Safety:* In order to achieve the goals outlined in Category 3 and 4 of this plan, San Mateo Medical Center will need to utilize advanced rapid improvement methodologies and train large teams of performance improvement experts and change agents. At SMMC, we see efficiency and quality as being inter-related: When the process of care delivery is of the highest quality and efficiency, more time and effort can be spent on value-added activities. In other words, a more efficient system can produce a higher quality output. By providing safer, higher quality care, patients' health outcomes will improve, along with their experience of the care.

Implementation Milestones

We will receive funding after meeting the following milestones in this project:

	Implement LEAN Methodologies					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Related Projects**
Implement LEAN Methodologies	52. **Milestone:** Continue LEAN Performance Improvement Project focused on Contract Services **Metric:** Documentation of Performance improvement project	53. **Milestone:** Implement at least 3 LEAN performance improvement events **Metric:** Number of performance improvement events 54. **Milestone:** Train Executive Leadership in LEAN methodologies **Metric:** Completion of training	55. **Milestone:** Implement at least 3 additional (total of 6 new events) LEAN performance improvement events **Metric:** Number of performance improvement events 56. **Milestone:** Train at least 5 medical providers and 10 additional staff as process improvement champions with expertise in LEAN methodologies **Metric:** Completion of training	57. **Milestone:** Implement at least 3 additional (total of 9 new events) LEAN performance improvement events **Metric:** Number of performance improvement events 58. **Milestone:** Train at least 5 additional (total of 10) medical providers and 10 additional staff (total of 20) as process improvement champions with expertise in LEAN methodologies **Metric:** Completion of training	59. **Milestone:** Implement at least 3 additional (total of 12 new events) LEAN performance improvement events **Metric:** Number of performance improvement events 60. **Milestone:** Train at least 5 additional (total of 15) medical providers and 10 additional staff (total of 30) as process improvement champions with expertise in LEAN methodologies **Metric:** Completion of training	• All projects (Cat. 1-4)

Category 3: Per the Waiver Terms and Conditions, the purpose of Category 3: Population-focused Improvement is "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." The Category 3 measure set includes measures that are: 1) Aligned with the low-income, Medicaid, and uninsured populations; 2) Identified as high priority given the health care needs and issues of the patient population served by San Mateo Medical Center; 3) Viewed as valid health care indicators to inform and fuel improvements in population health within the health care safety net.

Key Challenges:

- The patient and caregiver's experience of care is not always of sufficient value. In order for patients to receive high quality care they must feel that care is provided in a collaborative manner when and where they need it.

- Care is not always sufficiently coordinated to ensure optimal care. This can result in unnecessary hospitalizations for conditions that could and should have been more appropriately addressed in the ambulatory setting

- Patients do not always receive preventive care in an appropriate and timely manner. As a result, patients may suffer unnecessary illness, harm and cost.

- At-risk populations such as those with Diabetes, Congestive Heart Failure, Hypertension and Pediatric Asthma do not always receive optimal management and thus may suffer unnecessary complications and harm.

Major Delivery System Solutions:
As a data driven organization, San Mateo Medical Center believes that one of the key drivers for performance improvement is the collection, dissemination, display and analysis of accurate, relevant information. Therefore as part of its Category 3 plan, San Mateo Medical Center will:

- Collect and report patient experience data that includes questions from the "Clinician and Group Consumer Assessment of Healthcare Providers and Systems" (CG CAHPS) survey.

- Collect and report data on primary care patients who are hospitalized for potentially preventable conditions such as: short-term diabetic complications, uncontrolled diabetes, chronic obstructive pulmonary disease, and congestive heart failure.

- Collect and report data on the rates of indicated preventive health interventions in primary care patients. These interventions include: mammographic screening in appropriate women, age-appropriate influenza vaccination, pediatric weight screening, and smoking cessation counseling.

- Collect and report relevant outcomes data in specific at-risk populations including those with diabetes, congestive heart failure, hypertension, and pediatric asthma. This data will include cholesterol and blood sugar control in diabetics, appropriate blood pressure control in hypertensive patients, readmission rates for patients with congestive heart failure, and appropriate medication therapy in children with asthma. In addition, the organization will report data on overall diabetic care composite measures.

Implementation Milestones

We will receive funding after meeting the following milestones in this project:

	Patient/Care Giver Experience				
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Patient/Care Giver Experience		61. Undertake the necessary planning, redesign, translation, training and contract negotiations in order to implement CG-CAHPS in DY8.	62. 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 63. 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 64. 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 65. 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 66. 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	67. Report results of CG CAHPS questions for “Getting Timely Appointments, Care, and Information” theme to the State 68. Report results of CG CAHPS questions for “How Well Doctors Communicate With Patients” theme to the State 69. Report results of CG CAHPS questions for “Helpful, Courteous, and Respectful Office Staff” theme to the State 70. Report results of CG CAHPS questions for “Patients’ Rating of the Doctor” theme to the State 71. Report results of CG CAHPS questions for “Shared Decisionmaking” theme to the State	72. Report results of CG CAHPS questions for “Getting Timely Appointments, Care, and Information” theme to the State 73. Report results of CG CAHPS questions for “How Well Doctors Communicate With Patients” theme to the State 74. Report results of CG CAHPS questions for “Helpful, Courteous, and Respectful Office Staff” theme to the State 75. Report results of CG CAHPS questions for “Patients’ Rating of the Doctor” theme to the State 76. Report results of CG CAHPS questions for “Shared Decisionmaking” theme to the State

Implementation Milestones

We will receive funding after meeting the following milestones in this project:

Care Coordination					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Care Coordination		77. Report results of the Diabetes, short-term complications measure to the State **78.** Report results of the Uncontrolled Diabetes measure to the State	79. Report results of the Diabetes, short-term complications measure to the State 80. Report results of the Uncontrolled Diabetes measure to the State 81. Report results of the Congestive Heart Failure measure to the State 82. Report results of the Chronic Obstructive Pulmonary Disease measure to the State	83. Report results of the Diabetes, short-term complications measure to the State 84. Report results of the Uncontrolled Diabetes measure to the State 85. Report results of the Congestive Heart Failure measure to the State 86. Report results of the Chronic Obstructive Pulmonary Disease measure to the State	87. Report results of the Diabetes, short-term complications measure to the State 88. Report results of the Uncontrolled Diabetes measure to the State 89. Report results of the Congestive Heart Failure measure to the State 90. 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. *San Mateo Medical Center: Coastside Clinic*
2. *San Mateo Medical Center: Daly City Clinic*
3. *San Mateo Medical Center: Fair Oaks Adult Clinic*
4. *San Mateo Medical Center: Fair Oaks Children's Clinic*
5. *San Mateo Medical Center: Innovative Care Clinic*
6. *San Mateo Medical Center: Main Campus Pediatrics Clinic*

7. *San Mateo Medical Center: Ron Robinson Senior Care Center*

8. *San Mateo Medical Center: South San Francisco Clinic*

9. *San Mateo Medical Center: Willow Clinic*

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]

Implementation Milestones

We will receive funding after meeting the following milestones in this project:

	Preventive Health				
	Year 1	Year 2	Year 3	Year 4	Year 5
Preventive Health		91. Report results of the Mammography Screening for Breast Cancer measure to the State 92. Reports results of the Influenza Immunization measure to the State	93. Report results of the Mammography Screening for Breast Cancer measure to the State 94. Reports results of the Influenza Immunization measure to the State 95. Report results of the Child Weight Screening measure to the State 96. Report results of the Pediatrics Body Mass Index (BMI) measure to the State 97. Report results of the Tobacco Cessation measure to the State	98. Report results of the Mammography Screening for Breast Cancer measure to the State 99. Reports results of the Influenza Immunization measure to the State 100. Report results of the Child Weight Screening measure to the State 101. Report results of the Pediatrics Body Mass Index (BMI) measure to the State 102. Report results of the Tobacco Cessation measure to the State	103. Report results of the Mammography Screening for Breast Cancer measure to the State 104. Reports results of the Influenza Immunization measure to the State 105. Report results of the Child Weight Screening measure to the State 106. Report results of the Pediatrics Body Mass Index (BMI) measure to the State 107. Report results of the Tobacco Cessation measure to the State

Preventive Health Denominator:

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

1. *San Mateo Medical Center: Coastside Clinic*
2. *San Mateo Medical Center: Daly City Clinic*
3. *San Mateo Medical Center: Fair Oaks Adult Clinic*
4. *San Mateo Medical Center: Fair Oaks Children's Clinic*
5. *San Mateo Medical Center: Innovative Care Clinic*

6. *San Mateo Medical Center: Main Campus Pediatrics Clinic*
7. *San Mateo Medical Center: Ron Robinson Senior Care Center*
8. *San Mateo Medical Center: South San Francisco Clinic*
9. *San Mateo Medical Center: Willow Clinic*

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]

Implementation Milestones

We will receive funding after meeting the following milestones in this project:

	At-Risk Populations				
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
At-Risk Populations		108. Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State 109. Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State	110. Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State 111. Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State 112. Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State 113. Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State 114. Report results of the Pediatrics Asthma Care measure to the State 115. Report results of the Optimal Diabetes Care Composite for at least data from the last two quarters of the demonstration year to the State 116. Report results of the Diabetes Composite for at least data from the last two quarters of the demonstration year to the State	117. Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State 118. Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State 119. Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State 120. Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State 121. Report results of the Pediatrics Asthma Care measure to the State 122. Report results of the Optimal Diabetes Care Composite to the State 123. Report results of the Diabetes Composite to the State	124. Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State 125. Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State 126. Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State 127. Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State 128. Report results of the Pediatrics Asthma Care measure to the State 129. Report results of the Optimal Diabetes Care Composite to the State 130. Report results of the Diabetes Composite to the State

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

1. *San Mateo Medical Center: Coastside Clinic*

2. *San Mateo Medical Center: Daly City Clinic*
3. *San Mateo Medical Center: Fair Oaks Adult Clinic*
4. *San Mateo Medical Center: Fair Oaks Children's Clinic*
5. *San Mateo Medical Center: Innovative Care Clinic*
6. *San Mateo Medical Center: Main Campus Pediatrics Clinic*
7. *San Mateo Medical Center: Ron Robinson Senior Care Center*
8. *San Mateo Medical Center: South San Francisco Clinic*
9. *San Mateo Medical Center: Willow Clinic*

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 4: Per the Waiver Terms and Conditions, the purpose of Category 4: Urgent Improvement in Quality and Safety, is to make urgent improvements in care that: 1) have a promised impact on the patient population, 2) have a strong evidence base and 3) are meaningful to California's Public Hospital Systems. Therefore, San Mateo Medical Center's Category 4 includes the rapid implementation of evidence based interventions aimed at conditions and events that have significant morbidity and mortality within our patient population. San Mateo Medical Center is committed to providing its patients with the highest quality, safest medical care by using data to drive its improvement efforts.

Key Challenge: Patients seeking care for Sepsis suffer high rates of morbidity and mortality:

Sepsis, a form of severe bloodstream infection, can harm and kill patients if not treated quickly, and increases ICU length of stay and its associated costs. While and after receiving hospital services, challenges remain regarding the provision of safe, high-quality health care. Furthermore, it is critical to avoid causing harm or death to patients seeking care. Currently, approximately a quarter of patients with severe sepsis or septic shock die in public hospitals.

Major Delivery System Solutions:

- *Reduce avoidable harm or deaths due to severe sepsis in patients receiving inpatient services:* In support of our commitment to continuous quality improvement so that patients receive the safest and highest quality health care possible, we propose to make improvements in care provided to patients. We propose to improve severe sepsis detection and management to reduce unnecessary death and harm attributable to sepsis. Our interventions and improved processes are based upon the IHI recommended Surviving Sepsis Campaign to establish reliable detection and treatment for severe sepsis. This includes implementing the Sepsis Resuscitation Bundle. Since March of 2009, San Mateo Medical Center has participated in the Integrated Nurse Leadership Program's "Reducing Sepsis Mortality" initiative run out of the UCSF Center for the Health Professions. As part of this program, SMMC has begun to implement evidence based interventions to improve sepsis survival, but significant opportunities remain.

- *Expected Result:* Establish baseline bundle compliance in year two with significant targeted improvement in compliance by year five. Establish processes to measure and track impact of improved bundle compliance on overall sepsis mortality.

Implementation Milestones

We will receive funding after meeting the following milestones in this project:

	Improve Severe Sepsis Detection and Management				
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**

Improve Severe Sepsis Detection and Management	131. **Milestone:** Participate in Integrated Nurse Leadership Reducing Sepsis Mortality Collaborative **Metric:** Documentation of participation	132. **Milestone:** Implement the Sepsis Resuscitation Bundle **Metric:** Data submission through the INLP Reducing Sepsis Mortality Collaborative 133. **Milestone:** Report at Least 6 months of data collection on Sepsis Resuscitation Bundle to SNI for purposes of establishing the baseline and setting benchmarks**.** **Metric:** Report of data 134. **Milestone:** Report the Sepsis Resuscitation Bundle results to the State. **Metric:** Report of data	135. **Milestone:** Achieve 48% compliance with Sepsis Resuscitation Bundle, determined in Year 2 based on current DPH definition and DY 7 baseline data. **Metric:** Sepsis Resuscitation Bundle compliance rate 136. **Milestone:** Share data, promising practices, and findings with SNI to foster shared learning and benchmarking across the California public hospitals. **Metric:** Documentation of report 137. **Milestone:** Report Sepsis Resuscitation Bundle and sepsis mortality results to the State based on coded data definition (785.52 & 995.92). **Metric:** Documentation of report ***138.*** Milestone: Report Sepsis Resuscitation Bundle and sepsis mortality results to the State. Metric: Documentation of report	139. **Milestone:** Achieve 50% compliance with Sepsis Resuscitation Bundle, determined in Year 2 based on current DPH definition and DY 7 baseline data. **Metric:** Sepsis Resuscitation Bundle compliance rate 140. **Milestone:** Share data, promising practices, and findings with SNI to foster shared learning and benchmarking across the California public hospitals. **Metric:** Documentation of report 141. **Milestone:** Report Sepsis Resuscitation Bundle and Sepsis Mortality results to the State based on coded data definition (785.52 & 995.92). 142.. **Metric:** Documentation of report 143. Milestone: Report Sepsis Resuscitation Bundle and sepsis mortality results to the State. Metric: Documentation of report	144. **Milestone:** Achieve 53% compliance with Sepsis Resuscitation Bundle, determined in Year 2 based on current DPH definition and DY 7 baseline data. **Metric:** Sepsis Resuscitation Bundle compliance rate 145. **Milestone:** Share data, promising practices, and findings with SNI to foster shared learning and benchmarking across the California public hospitals. **Metric:** Documentation of report 146. **Milestone:** Report Sepsis Resuscitation Bundle and Sepsis Mortality results to the State based on coded data definition (785.52 & 995.92). **Metric:** Documentation of report 147. Milestone: Report Sepsis Resuscitation Bundle and sepsis mortality results to the State. Metric: Documentation of report

Key Challenge: Patients suffer from serious hospital acquired infections related to central lines:

Many hospitalized patients who require central lines are critically ill and have multiple co-morbidities. These patients often are at high risk for bloodstream infections related to their central lines and they can suffer significant injury if an infection occurs. It is essential to avoid causing harm or death to this highly susceptible population. Reductions in hospital acquired infections like central line associated bloodstream infections (CLABSI) represent a tremendous opportunity to improve quality, safety, and patient experience.

Major Delivery System Solutions:

- *Reduce the incidence of bloodstream infections related to central lines:* San Mateo Medical Center is committed to preventing avoidable harm. By using a bundle of validated interventions known as the Central Line Insertion Practices (CLIP), San Mateo Medical Center will work to reduce the incidence of CLABSI.

- *Expected Result:* Improved compliance with CLIP standards and demonstrate related reductions in CLABSI.

Implementation Milestones

We will receive funding after meeting the following milestones in this project:

	Central Line-Associated Bloodstream Infection (CLABSI) Infection Prevention				
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Central Line-Associated Bloodstream Infection (CLABSI) Infection Prevention	148. **Milestone:** Report Central Line Insertion Practices (CLIP) data to the National HealthCare Safety Network (NHSN) **Metric:** Report of data to NHSN	149. **Milestone:** Report at Least 6 months of data collection on CLIP to SNI for purposes of establishing the baseline and setting benchmarks. **Metric:** Report of data 150. **Milestone:** Report at Least 6 months of data collection on CLABSI to SNI for purposes of establishing the baseline and setting benchmarks. **Metric:** Report of data 151. **Milestone:** Report CLIP results to the State. **Metric:** Report of data	152. **Milestone:** Achieve 74% compliance with CLIP, determined in Year 2 based on baseline data. **Metric:** CLIP compliance rate 153. **Milestone:** Share data, promising practices, and findings with SNI to foster shared learning and benchmarking across the California public hospitals. **Metric:** Documentation of report 154. **Milestone:** Report CLIP and CLABSI results to the State. **Metric:** Documentation of report	155. **Milestone:** Achieve 80% compliance with CLIP, determined in Year 2 based on baseline data. **Metric:** CLIP compliance rate 156. **Milestone:** Reduce CLABSI's by X%, where "X" will be determined in Year 2 based on baseline data **Metric:** CLABSI rate 157. **Milestone:** Share data, promising practices, and findings with SNI to foster shared learning and benchmarking across the California public hospitals. **Metric:** Documentation of report 158. **Milestone:** Report CLIP and CLABSI results to the State. **Metric:** Documentation of report	159. **Milestone:** Achieve 95.7% compliance with CLIP, determined in Year 2 based on baseline data. **Metric:** CLIP compliance rate 160. **Milestone:** Reduce CLABSI's by X%, where "X" will be determined in Year 2 based on baseline data **Metric:** CLABSI rate 161. **Milestone:** Share data, promising practices, and findings with SNI to foster shared learning and benchmarking across the California public hospitals. **Metric:** Documentation of report 162. **Milestone:** Report CLIP and CLABSI results to the State. **Metric:** Documentation of report

Key Challenge: Patients may experience serious complications related to Surgical Site Infections:

Hospital Acquired Infections represent a significant source of preventable morbidity and mortality in hospitalized patients. It is estimated that approximately 17% of all hospital acquired infections are related to surgical site infections.[6] San Mateo Medical Center is committed to reducing preventable harm. However, the organization does not currently have good data to measure and track Surgical Site Infections.

Major Delivery System Solutions:

- *Reduce Surgical Site Infections:* San Mateo Medical Center will work to document the rate of Surgical Site Infections at our institution. Utilizing documented best practices including superior compliance with the Surgical Care Improvement Project interventions, we will reduce the rate of surgical site infections.

- *Expected Result:* Reduce the rate of Surgical Site Infection for the 20 surgical procedures types as defined by NHSN that are performed at SMMC, including: appendix surgery, bile -duct, liver or pancreatic surgeries, gallbladder surgery, colon surgery, spinal fusion, open reduction of fracture, gastric surgery, hip prosthesis, abdominal hysterectomy, knee prosthesis, laminectomy, kidney surgery, ovarian surgery, pacemaker surgery, rectal surgery, small bowel surgery, spleen surgery, thoracic surgery, vaginal hysterectomy, and exploratory abdominal surgeries as compared with baseline established in year 2. SMMC does not perform seven (7) procedures of the 29 procedures requested the California Department of Public Health (CDPH) including (Cardiac surgery, Coronary artery bypass graft with chest incision only, Cesarean section, Heart transplant, Kidney transplant, and Liver Transplant) and therefore these were not included; similarly, SMMC did not perform 2 procedures (cardiac surgery and refusion of spine) during the baseline period and thus these were not included in the expanded universe.

  *Given the imper*ative to establish a baseline for improvement in the prevention of SSIs in DY7 and the recently adopted technical specifications for surgical site infections that exclude superficial SSIs, it is necessary that SMMC expand the total number of surgical procedures to produce a more meaningful performance data set with the capacity to demonstrate incremental, year over year improvement through DY 10. In addition, the expanded full set of surgical procedures provides a more representative picture of SSI infections at SMMC and will demonstrate house-wide improvement over time.

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[6] Klevens RM, Edwards JR, et al. Estimating health care-associated infections and deaths in U.S. hospitals, 2002. Public Health Reports 2007;122:160-166.

1. Implementation Milestones

We will receive funding after meeting the following milestones in this project:

	Surgical Complications Core Processes (SCIP)				
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Surgical Complications Core Processes (SCIP)	163. **Milestone:** Designate interdisciplinary team to lead process to capture and analyze Surgical Site Infection (SSI) data.	164. **Milestone:** Report at Least 6 months of data collection on SSI for Class 1 and 2 wounds in two surgical procedures: laparoscopic cholecystectomy and knee prosthesis for purposes of establishing the baseline and setting benchmarks**.** **Metric:** Report of data 165. **Milestone:** Report the rate of SSI for Class 1 and 2 wounds in two surgical procedures: laparoscopic cholecystectomy and knee prosthesis to the State. **Metric:** Report of data	166. **Milestone:** Reduce the rate of SSI for Class 1 and 2 wounds in 20 surgical procedures performed at SMMC to 2.75% based on DY 7 baseline data. **Metric**: SSI rate for Class 1 and 2 wounds 167. **Milestone:** Share data, promising practices, and findings with SNI to foster shared learning and benchmarking across the California public hospitals. **Metric:** Documentation of report 168. **Milestone:** Report SSI results for Class 1 and 2 wounds for 20 surgical procedures performed at SMMC to the State. **Metric:** Documentation of report	169. **Milestone:** Reduce the rate of SSI for Class 1 and 2 wounds in 20 surgical proceduresperformed at SMMC to 2.5% based on DY 7 baseline data. **Metric**: SSI rate for Class 1 and 2 wounds 170. **Milestone:** Share data, promising practices, and findings with SNI to foster shared learning and benchmarking across the California public hospitals. Metric: Documentation of report 171. **Milestone:** Report SSI results for Class 1 and 2 wounds for 20 surgical procedures performed at SMMC to the State. **Metric:** Documentation of report	172. **Milestone:** Reduce the rate of SSI for Class 1 and 2 wounds in 20 surgical procedures performed at SMMC to 2.25based on DY 7 baseline data. **Metric**: SSI rate for Class 1 and 2 wounds 173. **Milestone:** Share data, promising practices, and findings with SNI to foster shared learning and benchmarking across the California public hospitals. **Metric:** Documentation of report 174. **Milestone:** Report SSI results for Class 1 and 2 wounds for 20 surgical proceduresperformed at SMMC to the State. **Metric:** Documentation of report

Key Challenge: Patients can suffer significant injuries due to falls in the acute care setting:

Falls are a significant cause of preventable injury in the acute care setting and according to the Institute for HealthCare Improvement; falls are the leading cause of death in hospitals for patients 65 and older. San Mateo Medical Center is committed to keeping all of its patients safe, and therefore is focused on eliminating falls with injury in its acute care setting.

Major Delivery System Solutions:

- *Reduce the prevalence of falls with injury:* San Mateo Medical Center will work to document the rate of falls with injury at our institution. In order to reduce the prevalence of falls, SMMC will utilize best practices which will include: appropriate assessment of risk for falling, communication to staff regarding individual patient risk for falling, and institution of specific interventions for patients at risk for falling.

- *Expected Result:* Achieve a rate of zero falls with injury per 1000 patient days for at least 6 months of a year.

Implementation Milestones

We will receive funding after meeting the following milestones in this project:

	Prevent Falls with Injury				
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Prevent Falls with Injury	175. **Milestone:** Report falls data to Collaborative Alliance for Nursing Outcomes (CALNOC) **Metric:** Report of data	176. **Milestone:** Share data, promising practices, and findings with SNI to foster shared learning and benchmarking across the California public hospitals. **Metric:** Documentation of report 177. **Milestone:** Report falls with injury to the State. **Metric:** Documentation of report	178. **Milestone:** Share data, promising practices, and findings with SNI to foster shared learning and benchmarking across the California public hospitals. **Metric:** Documentation of report 179. **Milestone:** Report falls with injury to the State. **Metric:** Documentation of report	180. **Milestone:** Achieve *one* fall with injury per 1000 patient days for at least six months out of a year (months are not necessarily consecutive) **Metric:** Rate of falls with injury per 1000 patient days 181. **Milestone:** Share data, promising practices, and findings with SNI to foster shared learning and benchmarking across the California public hospitals. **Metric:** Documentation of report 182. **Milestone:** Report falls with injury to the state **Metric:** Documentation of report	183. **Milestone:** Achieve *zero* falls with injury per 1000 patient days for at least six months out of a year (months are not necessarily consecutive) **Metric:** Rate of falls with injury per 1000 patient days 184. **Milestone:** Share data, promising practices, and findings with SNI to foster shared learning and benchmarking across the California public hospitals. **Metric:** Documentation of report 185. **Milestone:** Report falls with injury to the State. **Metric:** Documentation of report

Category 5: Per the California Section 1115 Waiver Terms and Conditions, the purpose of Category 5: HIV Transition Projects is to support the transition of Ryan White clients to the Low Income Health Program and drive quality and service delivery improvements for the benefit of the HIV patient community. This Plan Modification was developed in collaboration with the appropriate clinical and administrative leaders in the Health System, the Public Health Division, SMMC and the San Mateo County HIV Community Board to benefit the HIV community in San Mateo County.

Stakeholders and the development of Category 5. Plan components were carefully chosen to build capacity in service delivery at the San Mateo County Edison Clinic, which is located within the San Mateo Medical Center but is operated solely by Public Health – STD/HIV Program. This plan was created in collaboration with the following stakeholder members and entities:

- Carol Marks – San Mateo Medical Center (SMMC), 1115 Waiver Manager
- Matt Geltmaker, LCSW – STD/HIV Program Director, AIDS Director
- Dr. Karen Relucio – Medical Director, Public Health Clinics and STD/HIV Program
- Anita Booker – Public Health Clinics Manager, Edison Clinic Manager
- San Mateo County HIV Community Board
- Srija Srinivasan – LIHP Administrator and Director of Strategic Operations, San Mateo County Health System

The roles for each of the stakeholders are described below:

- The San Mateo Medical Center is the Designated Public Hospital (DPH) for San Mateo County. As such, they are responsible for reporting all DSRIP categories to DHCS.
- The STD/HIV Program is located within the Public Health division of the San Mateo County Health System. The STD/HIV Program has oversight for all Ryan White and HOPWA funding for San Mateo County HIV Prevention funding received from the CDC, STD and HIV surveillance activities.
- Edison Clinic is a Public Health clinic located within SMMC. Public Health rents the clinic space from SMMC and provides all clinic operations, including staff and ancillary expenses. Edison Clinic provides outpatient/ambulatory medical care to HIV-positive residents of San Mateo County with a wide-range of payer sources; Medicare, Medi-Cal, LIHP and no payer source other than Ryan White.
- The San Mateo County HIV Community Board is a volunteer group of individuals that represent the interests of persons living with HIV/AIDS in San Mateo County. Board members include consumers, advocates, contract agencies and non-affiliated residents of the county. The Board advises the San Mateo County STD/HIV Program and provides ongoing direction about program policy, planning and development of all HIV/AIDS prevention and care services for San Mateo County residents.
- The Director of Strategic Operations oversees the Health Coverage Unit, which conducts outreach, enrollment and retention activities to further the Health System's goals of universal health insurance coverage in San Mateo County. The work of this unit reaches an estimated 41,000 residents/ year to assist them with enrolling in all of the public health coverage programs for children and adults -- Medi-Cal, Healthy Families, LIHP, the County's indigent care program (ACE), and the County's locally sponsored children's coverage program (Healthy Kids).

Stakeholders were representatives of the four major categories listed below:

- **Provider:** Dr. Karen Relucio – Medical Director, Public Health Clinics and STD/HIV Program, Anita Booker – Public Health Clinics Manager, Edison Clinic Manager, Matt Geltmaker, LCSW – STD/HIV Program Director, AIDS Director
- **Consumer:** San Mateo County HIV Community Board
- **Advocate:** San Mateo County HIV Community Board
- **DPH/LIHP:** Carol Marks – San Mateo Medical Center (SMMC), Srija Srinivasan – LIHP Administrator and Director of Strategic Operations, San Mateo County Health System

As the clinical provider, Dr. Karen Relucio's expertise and role as the Medical Director of Public Health Clinics and STD/HIV Program ensured that optimal patient care was the focus of the plan. Dr. Relucio is board certified through the American Board of Internal Medicine in the subspecialty of Infectious Diseases and the specialty of Internal Medicine. She has recently completed recertification in both specialties in 2011. She has been in HIV clinical practice since 1999 and has served as the Medical Director for the Edison Clinic and STD/HIV Program since 2009.

Different subsets of the local stakeholders met throughout the planning and development of the project. The Providers met with the DPH/LIHP representatives to develop a framework for the plan development, including roles and responsibilities. The STD/HIV Program Director met with the HIV Community Board twice to discuss the plan and the specific performance measures being chosen for the plan. The Providers met at least weekly during the planning and writing phase. The Providers then presented the final plan to the DPH/LIHP representatives to incorporate into the full DPH DSRIP proposal.

Having the sole providers of Ryan White and LIHP-funded HIV care in the county being the main drivers of the DSRIP Category 5 planning ensures that optimal patient care is at the forefront during this transition.

Our STD/HIV Program Director, who is of the liaison to the San Mateo County HIV Community Board and a member of the State Office of AIDS LIHP Advisory Committee, has attended the State Office of AIDS LIHP stakeholders' calls throughout the planning process.

Feedback from the HIV Community Board informed the use of specific performance measures that the board sees as having greatest impact to individuals with HIV in San Mateo. For example, the board was interested in screening for syphilis, gonorrhea and Chlamydia due to the increased rates of these sexually transmitted diseases in the county, both in HIV-positive and HIV-negative populations

The Providers are responsible for the data extraction and collection for all performance measures in Category 5. The STD/HIV Program Director is the liaison with the Information Systems Department (ISD) for the implementation of data extraction and compilation. These two entities are meeting every other week to monitor progress on the data extraction. The DPH/LIHP representatives are being informed as to progress but are not directly involved in the implementation of this process.

Once the data extraction process is implemented, the Providers will be responsible for 1) providing written reports to the DPH/LIHP representatives to be submitted with the entire DSRIP report and 2) providing the data to the Consumer and Advocate representatives during the quarterly HIV Community Board meetings. Individual patient data will also be provided to the clinicians and medical case managers in Edison Clinic to assist in providing optimal primary medical care to the patients.

Plan components correlate with DSRIP program goals for the SAN MATEO MEDICAL CENTER.

San Mateo County Public Health – STD/HIV Program. The STD/HIV Program is the administrator of all Ryan White and Housing Opportunities for People With AIDS (HOPWA) funded services in San Mateo County. Overall, the program provided Ryan White funded services to 668 persons with HIV/AIDS during the fiscal year 2011-2012. These services include funding from Ryan White Part A & B as well as HOPWA. The demographics of the HIV population receiving Ryan White and HOPWA funded services in San Mateo County during 2011-2012 are shown in the table on the following page:

Demographic Summary of HIV Positive Clients receiving Ryan White and HOPWA funded services 2011-2012

July 2011- June 2012 (n=668)

Gender	**Percentage**
Male (517)	77.4%
Female (137)	20.5%
Transgender Male to Female (14)	2.1%
Age (yrs)	
20-29 (45)	6.7%
30-39 (134)	20.1%
40-49 (217)	32.5%
50-59 (194)	29.0%
60-69 (69)	10.3%
>70 (9)	1.4%

Race/Ethnicity	
White (203)	30.4%
Hispanic (270)	40.4%
Black (117)	17.5%
Asian/Pacific Islander (39)	5.8%
American Indian/Native Alaskan (5)	0.8%
Mixed race or Unknown (34)	5.1%
Risk Behaviors	
MSM (300)	44.9%
IDU (87)	13.0%
MSM and IDU (29)	4.3%
Heterosexual (64)	9.6%
Unknown or undetermined (173)	26.0%
Transfusion (15)	2.2%

The San Mateo Medical Center is the Designated Public Hospital (DPH) in San Mateo County. Edison Clinic is the only Ryan White funded clinic in San Mateo County and is located within the San Mateo Medical Center. San Mateo County Public Health rents the Edison Clinic space from the San Mateo Medical Center and supports all clinic operations, including staff and ancillary expenses. Edison Clinic provides outpatient/ambulatory medical care to HIV-positive residents of San Mateo County with a wide-range of payer sources; Medicare, Medi-Cal, LIHP and no payer source other than Ryan White. Edison Clinic uses the same electronic health system, ancillary services and specialty referral network as San Mateo Medical Center. Edison Clinic has a smaller clinic population and less patient access difficulties, making it possible to empanel 100% of HIV positive clients within our clinic healthcare team. Edison Clinic will be incorporating some, but not all of the Category 2 measures, including expanded staff roles, the chronic care model, coordination of care with support staff and wrap-around services, effective use of health information technology, performance outcomes measurement, and health promotion and education.

Outpatient/Ambulatory care. HIV patients receive ambulatory care from the medical staff of Edison Clinic that is comprised of six part-time healthcare providers who actively manage anywhere between 25-100 HIV-infected patients, three full-time Registered Nurses (RN) and one full-time Medical Specialist Assistant (MSA).

A key responsibility of the nursing staff is patient education related to the patient's medical conditions and medication adherence. Duties also include calling in prescriptions and refills, reviewing medications with the patient, assessing for medication allergies, and providing any necessary immunizations/and injectable medications. Nursing staff also obtain verbal and phone order from providers, check labs and notify providers of abnormal lab results and follow-up orders, if any. Nurses are responsible for patient assessments for urgent visit and triage phone calls. Prior to seeing the medical provider, the nursing staff takes the patient's vitals, provides education, documents new complaints, and reconciles the patient's medications.

New patient medical intakes and screening is handled by the nursing staff who request the patient's previous medical records, assess their current medical needs, identify current medications, order necessary labs, administer necessary immunizations, and schedule patients for a provider visit. They also participate in the Edison Clinic's Continuous Quality Improvement projects.

Wrap-around services. In addition to primary HIV ambulatory medical care, Edison Clinic also provides wrap-around services onsite. These services include mental health, medical case management, medical transportation, outpatient substance use treatment, housing, emergency financial assistance, harm reduction therapy, referral to dental services, referral to food programs and referral to residential substance use treatment. Many of these services are provided by contracted agencies. These contracted agencies provide staff both on site at Edison Clinic as well as at their respective agencies within San Mateo County. The placement of these services in one clinic facilitates convenient and coordinated access for patients as well as an easier referral system for providers. All Ryan White and HOPWA funded services provided throughout San Mateo County by contracted agencies are also tracked in ARIES.

Medical Case Management. Medical case management is provided by Licensed Marriage & Family Therapists and Licensed Clinical Social Workers. In keeping with the National HIV/AIDS Strategy (NHAS), medical case managers focus on retention in care along with partner services, other prevention with positives activities, and referrals and linkage to social services. A Financial Benefits Specialist provides individual assistance to all clients in order to assess for appropriate benefit programs and assist in the application process. Clients are assisted in applying for LIHP, Medi-Cal, ADAP, Office of AIDS – Health Insurance Premium Payment (OA-HIPP) and Office of AIDS – Pre-Existing Condition Insurance Plan (OA-PCIP). HIV treatment adherence is regularly assessed by medical providers, nurses and medical case managers. Client-centered, multidisciplinary HIV prevention is provided by medical case managers, healthcare providers, nursing staff, STD/HIV community workers, and harm reduction therapists. The harm reduction therapists address all high-risk behaviors including sexual and substance use.

Data collection and reporting. The data collection systems to support reporting needs for the HIV population have been evolving. Edison Clinic staff began capturing all Ryan White and HOPWA funded services in ARIES (AIDS Regional Information and Evaluation System) since 2008. The San Mateo Medical Center and Edison Clinic implemented eClinical Works (eCW) as the electronic medical record for all outpatient clinics in 2009. Even with the implementation of the electronic medical record,

significant data re-entry and data reconciliation is required as the systems do not communicate directly. One of the projects identified in Category 5a is designed to reduce this labor intensive process, enable the reporting of HRSA HAB data in Category B, and improve access to and the quality of reportable data .

DSRIP Category 5 is critical to sustaining a high level of service delivery for patients with HIV as they transition from Ryan White to LIHP (and ultimately to Medi-Cal in 2014) for several reasons. This entire patient population has significant psycho-social issues that impact access to care. These psycho-social issues include incomes less than 400% of Federal Poverty Limit (FPL), unstable housing and homelessness, aging, mental health and substance use. This population also experiences significant co-morbidities that require more intensive medical case management through clinical pharmacy and nutritional services. San Mateo County also experiences a higher prevalence (62%) of HIV late testing, defined as AIDS diagnosis within one year of HIV diagnosis, than our neighboring county of San Francisco (39%) and the national average (43%). High levels of medical case management are required to engage, retain and re-engage, when necessary, this patient population. Systems monitoring clinical performance measures are needed in order to provide this high level of medical care and case management. DSRIP Category 5 funding will assist in building the infrastructure of data exchange in order to monitor the clinical performance measures for this distinct population. Note that Category 5 DSRIP measures listed on page are separate measures that are specific to Edison Clinic.

The DSRIP Category 5 HIV Transition Projects we have chosen are in alignment with the goal of Increasing Access to Care and Improving Health Outcomes for People Living with HIV from the National HIV/AIDS Strategy. Through the empaneling of patients into medical homes with HIV expertise and ensuring access to Ryan White wrap-around services, clinical care providers will be able to ensure that all eligible HIV-positive persons have access to and are maintained on a medication regimen as recommended by the HHS treatment guidelines (Step 1.3). We will also be able to support people living with HIV with co-occurring health conditions and those who have challenges meeting their basic needs, such as housing (Step 3). With the enhancement of data sharing between the DPH and our Public Health systems, we will be able to facilitate linkages to care (Step 1.1), promote collaboration among providers (Step 1.2), and enhance client assessment tools and measurement of health outcomes (Step 3.1).

The following data from Attachment Q – Supplement 1 will be collected and analyzed: baseline CD4 counts, percentage of patients on HAART, medical visit data, percentage of patients with CD4<200 on PCP prophylaxis, percentage of patients in which viral load monitoring is performed, percentage of patients with undetectable viremia, and percentage of patients screened for of chlamydia, gonorrhea and syphilis. All of the data will be shared at the Quality Improvement Committee meetings at San Mateo Medical Center, Public Health departmental meetings and the HIV Community Board.

Category 5a

Improve Infrastructure and Program Design for patients with HIV

Intervention #1: Empanel patients into medical homes with HIV expertise

Key Challenge: HIV patients, regardless of payer source, will need comprehensive services through a medical home that provides comprehensive HIV primary care, high-level wrap-around services that can ensure retention and access to care, case management to implement HIV transmission risk reduction strategies, and medication adherence.

The success of HIV treatment depends on successful empanelment into medical homes where HIV expertise is available. Medical homes strengthen the quality of care delivered, as dedicated physician-led teams develop a strong relationship with each patient. This is especially important when serving patients with HIV who have more complex panel management that includes following traditional HIV disease indicators, concomitant co-morbidities, HIV risk transmission reduction strategies, medication adherence, and wrap-around services (e.g. nutrition, pharmacy, behavioral health, substance abuse, social work services, oral health) that ensure retention and access to care. All of these measures are required to prevent progression of disease and secondary HIV transmission.

Major Delivery System Solution: Empanel patients into medical homes with HIV expertise.

In support of our commitment to continuous quality improvement so that patients receive the safest and highest quality health care possible, we propose to implement an HIV medical home by selecting an optimal staffing model for the Edison Clinic to ensure provision of multi-disciplinary team-based care to optimize access, retention, and treatment adherence and improve health outcomes and self- management. The existing clinical staff are comprised of six part-time healthcare providers (total of 1.2 FTE) who actively manage anywhere between 25-100 HIV-infected patients. Five providers are board certified in Infectious Diseases and one provider is board certified in Internal Medicine, with additional certification from the American Academy of HIV medicine. There are also three full-time Registered Nurses (RN) and one full-time Medical Specialist Assistant (MSA); three of the four nursing staff have worked at Edison Clinic for 15 years or more. There are three medical case managers.

Currently, all HIV positive new patients who access medical care or former patients who re-establish medical care at Edison Clinic undergo an intake process, with the goal of 100% empanelment. This intake process includes: 1) determination of eligibility, 2) psychosocial assessment to determine need for wrap-around services, 3) nursing intake for obtaining medical history, current symptoms, baseline laboratory testing, and immunizations and 4) assignment to an HIV-specialist primary care provider for a new patient visit. Currently, primary care assignments are based on available capacity on each provider's panel or based on first available appointment for patients with more complex or acute medical issues. Once patients are assigned a primary care provider, they are seen for an initial patient visit. Subsequent follow up medical, laboratory, and medical case management appointments are scheduled in 1-6 months, depending on the complexity of medical or psychosocial issues.

The goal is to empanel 500 patients for every 1 FTE, but this goal may increase based on demand for HIV services. Currently, each provider's panel assignments are not based on panel weighting, which results in disproportionate representation of complex patients among providers who work at higher percentage of an FTE. Unique panel weighting/patient risk-adjustment methodologies will be developed based on existing clinical risk group (CRG) models for weighting patients according to time since HIV diagnosis, utilization of HIV care services, coexisting co-morbidities, and difficulty in adhering to treatment plans. Panel weighting will ensure appropriate and safe empanelment across medical providers at Edison Clinic, appropriate to level of training (MD vs. NP or PA). Edison Clinic will stratify its current patient population based on co-existing conditions that place patients into risk categories: 1) Extreme: patients with co-existing catastrophic conditions (dialysis dependency, total parenteral nutrition, ventilator-dependency, transplant recipients, persistent vegetative state, neurodegenerative disease), 2) Major: patients with co-existing dominant chronic disease in three or more organ systems (HIV with congestive heart failure, COPD, diabetes, chronic kidney disease), 3) Moderate: patients with co-existing significant chronic disease in multiple organ systems (HIV with hypertension, diabetes, hyperlipidemia), 4) Minor: single dominant or moderate chronic disease (HIV only).

Physician healthcare providers will be assigned a proportional share of extreme, major, moderate, and minor patients (e.g. 5% extreme, 10% major, 40% moderate, and 45% minor). Non- physician healthcare providers , such as nurse practitioners and physician assistants, will not be assigned extreme category patients and will be assigned proportionately less major risk-category patients than physician providers, with the goal of assigning them predominantly moderate and minor cases (e.g. 60% minor, 45% moderate, 5% major). Future empanelment of HIV positive patients into medical homes will take into consideration both panel size and proportion of risk category patients. The highest risk-category patients will be offered the most comprehensive wrap-around services, whereas lower risk category patients will be offered psychosocial screening during their eligibility assessment.There are currently mechanisms in place for ensuring engagement to care and medication adherence which will be improved by adding pharmacy services. All patients who have not attended a medical or laboratory appointment within a 6 month period are contacted by nursing staff to schedule an appointment. Patients who do not return calls are referred to medical case management and STD/HIV outreach for re-engagement to care. In terms of medication adherence, HIV viral load laboratory reports are reviewed by the Edison Clinic manager weekly. Any patients identified as having a viral load greater than 200 copies/mL while on antiretroviral therapy are contacted by nursing, and an adherence questionnaire is administered. Nursing provides feedback to the patient's primary care provider about barriers to adherence. Depending on the barrier to adherence, medication adherence issues may addressed at a provider visit, resolved by nursing, or referred to medical case management, psychiatry, Harm Reduction Therapy or substance abuse. The Edison Clinic's goal is to enhance these services by hiring or recruiting HIV Clinical Pharmacist volunteers from pharmacy schools, who can help patients navigate complex pharmacy refill processes, assess drug interactions that may lead to decreased antiretroviral drug levels and drug resistance, and design more effective antiretroviral regimens based on HIV genotypic and phenotypic data.

Empanel patients into medical homes with HIV expertise				
DY 7	**DY 8, First 6 months (Jul 1, 2012-Dec 31, 2012)**	**DY 8, Second 6 months (Jan 1, 2013-Jun 30, 2013)**	**DY 9, First 6 months (Jul 1, 2013-Dec 31, 2013)**	**Related Projects (Categories I-V)**
	112. Milestone: Select/develop optimal staffing model for use in medical homes that care for patients with HIV • **Metric:** Selection of staffing guidelines as per IDSA/HIVMA policy paper (Clin Infect Dis. (2011) doi: 10.1093/cid/cir689)	**113. Milestone:** Define the roles and responsibilities of team members • **Metric:** Documentation describing roles and responsibilities of existing clinic staff as per the IDSA/HIVMA policy staffing model.	**114. Milestone:** Implement a staffing model appropriate for LIHP patients empanelled in a medical home with HIV expertise, including pharmacy and medication adherence services for patients with advanced disease and co-morbidities • **Metric:** Assignment of staffing that provides medication adherence services and recruitment of clinical pharmacists from pharmacy schools who can volunteer. **115. Milestone:** Develop patient weighting/risk-adjustment algorithms for assigning patients with HIV to medical homes • **Metric:** Adoption of the 3M clinical risk grouping model to assign HIV positive patients to four subclasses: minor (1), moderate (2), major (3), and extreme (4) severity of illness. This model will take into consideration other co-morbidities. Gather utilization data from Health Plan of San Mateo to see how many patients fall into the four subclasses.	• Redesigning Primary Care (Cat. 2) • Spreading Primary Care Medical Homes (Cat. 2) • Improving the care of HIV populations (Cat. 5)

Empanel patients into medical homes with HIV expertise				
DY 7	**DY 8,** **First 6 months** **(Jul 1, 2012-Dec 31, 2012)**	**DY 8,** **Second 6 months** **(Jan 1, 2013-Jun 30, 2013)**	**DY 9,** **First 6 months** **(Jul 1, 2013-Dec 31, 2013)**	**Related Projects (Categories I-V)**
			116. Milestone: Empanel patients into medical homes • **Metric:** Distribute weighted patient census to each provider.	

Category 5a

Improve Infrastructure and Program Design for patients with HIV

Intervention #2: Enhance data sharing between DPH system providers and the County Departments of Public Health

Key Challenge: Maintaining uninterrupted, high-quality care to all HIV-positive patients, regardless of payer source, during the transitions under the Affordable Care Act (ACA).

As HIV patients transition from Ryan White to the LIHP and ultimately to Medi-Cal in 2014 under ACA, robust data sharing and exchange are critical to ensuring that access and high-quality care remains uninterrupted and that all patients, regardless of payer source, are cared for according to the same high level of standards and goals of care. Improved data sharing will also enhance public health efforts to track and improve population health, reduce morbidity and mortality, and reduce forward transmission.

Major Delivery System Solution: Enhance data sharing between eClinical Works (DPH system) and ARIES (Public Health system).

In support of our commitment to continuous quality improvement so that patients receive uninterrupted and high quality health care, we propose to make enhancements in the data sharing between the DPH system (eClinical Works) and the Public Health system (ARIES). We propose to design and implement an electronic data exchange that will include specific individual patient-level data (HIV clinical measures) related to quality of care. The HIV clinical measures chosen are based upon HRSA HAB Performance Measures. The electronic data exchange will allow for enhanced reporting of HRSA HAB Performance Measures to our partners in the San Francisco Ryan White Part A Eligible Metropolitan Area (EMA), which includes San Francisco, Marin and San Mateo. The enhanced reporting of HRSA HAB Performance Measures will also allow for better quality reporting to the California Department of Public Health-State Office of AIDS (CDPH-SOA), and to DHCS and CMS through the DSRIP program.

Two representatives from the San Mateo County Information Services Department , in collaboration with the STD/HIV Director, will provide a report that exports data from eCW and Invision for CD4 counts, HIV viral load, antiretroviral prescriptions, PCP prophylaxis, medical visits, and STD testing to an Excel spreadsheet on a weekly basis. This report will be uploaded to ARIES by the STD/HIV Director. Feedback and reminders to order screening tests or PCP prophylaxis will be provided to each healthcare provider. Quality metrics for percentages of empaneled patients who undergo appropriate laboratory screening, medical visits, and PCP prophylaxis will be provided to each primary care provider on a quarterly basis, as part of their ongoing performance evaluations.

Enhance data sharing between DPH system providers and the County Departments of Public Health				
DY 7	**DY 8, First 6 months (Jul 1, 2012-Dec 31, 2012)**	**DY 8, Second 6 months (Jan 1, 2013-Jun 30, 2013)**	**DY 9, First 6 months (Jul 1, 2013-Dec 31, 2013)**	**Related Projects (Categories I-V)**
	117. Milestone: Identify and map data fields that will be included in data exchange**.** • **Metric:** Documentation of data fields that will be provided to Information Services Department (ISD) that are necessary to facilitate the electronic data exchange **118. Milestone:** Develop and implement the data exchange. • **Metric:** Proposal from ISD to develop, test and implement data exchange. Public Health to begin utilizing data exchange.	**119. Milestone:** Establish and implement protocols and procedures for ongoing monitoring of data exchange. • **Metric:** Public Health will create and implement protocol and procedure. **120. Milestone:** Establish and implement protocols and procedures for use of data to improve quality of care and population health. • **Metric:** Public Health will create and implement protocol and procedure.	**121. Milestone:** Continue to monitor accuracy of data exchange. • **Metric:** Public Health will monitor monthly the accuracy of the data, reporting any errors to ISD. **122. Milestone:** Continue to utilize data to improve quality of care and population health. • **Metric:** Public Health will review data monthly in Clinic Operations meetings. **123. Milestone:** Monitor for additional clinical measurement data fields to be added to data exchange • **Metric:** Public Health will review data monthly in Clinic Operations meetings.	• Redesigning Primary Care (Cat. 2) • Spreading Primary Care Medical Homes (Cat. 2) • Improving the care of HIV populations (Cat. 5)

Category 5a

Improve Infrastructure and Program Design for patients with HIV

Intervention #3: Ensure access to Ryan White wrap-around services for new LIHP enrollees

Key Challenge: All HIV patients, regardless of payer source for medical care, will continue to require wrap-around services in order to remain engaged in care and address their barriers to care.

Regardless of the payer of medical care, Ryan White eligible clients will continue to be eligible for wrap-around services. New LIHP enrollees, either transferring from existing Ryan White medical care or new to HIV care, will need to have the same information and access regarding these services in order to remain engaged in care. Care coordination services comprised of multidisciplinary teams located within the medical home have been shown to improve access and retention, while addressing other factors that may create barriers to continued, effective engagement in medical care.

Major Delivery System Solution: Ensure access to Ryan White wrap-around services for new LIHP enrollees.

To ensure that our HIV patients receive the safest and highest quality health care possible, we propose to establish a mechanism between LIHP enrollment workers and Ryan White medical case managers to assure that all HIV patients are assessed for wrap-around services. The Ryan White medical case managers will assess all clients, regardless of medical care payer source, for factors that may create barriers to continued, effective engagement in medical care, such as housing, mental health services, substance use treatment, treatment adherence counseling, transportation, emergency financial assistance, harm reduction therapy, food assistance and oral health services. These assessments occur during new patient intake, every 6 months during eligibility screening, and at a patient's request. Most of these wrap-around services are provided by contract agencies that will collaborate with the medical case managers in the multidisciplinary case conferences. Monthly case conferences are held for each provider's caseload and are used to determine a patient's need for wrap-around services, as well as providing communication between contract agencies and the medical care team.

Ensure access to Ryan White wrap-around services for new LIHP enrollees				
DY 7	**DY 8, First 6 months (Jul 1, 2012-Dec 31, 2012)**	**DY 8, Second 6 months (Jan 1, 2013-Jun 30, 2013)**	**DY 9, First 6 months (Jul 1, 2013-Dec 31, 2013)**	**Related Projects (Categories I-V)**
	124. Milestone: Establish a mechanism between LIHP enrollment workers and Ryan White medical case managers to ensure that transitioned HIV patients continue to be assessed for wrap-around services. • **Metric:** Documentation of mechanism between LIHP enrollment workers and Ryan White medical case managers.	**125. Milestone:** Ensure care coordination with each medical provider at Edison Clinic through regularly scheduled multi-disciplinary case conferences and eligibility screenings to assess need for specific wrap-around services • **Metric:** Documentation of multidisciplinary case conferences.	**126. Milestone:** Continue to ensure care coordination with each medical provider at Edison Clinic through regularly scheduled multi-disciplinary case conferences and eligibility screenings to assess need for specific wrap-around services. • **Metric:** Documentation of multidisciplinary case conferences. **127. Milestone:** Monitor any co-factors that create barriers to care in order to promote retention and re-engagement in care • **Metric:** Document discussion of barriers to care through monthly Clinic Operations meeting.	• Redesigning Primary Care (Cat. 2) • Spreading Primary Care Medical Homes (Cat. 2) • Improving the care of HIV populations (Cat. 5)

Category 5b

Improve Clinical and Operational Outcomes for patients with HIV

Intervention #1: HIV Core Clinic Performance Measures (Required)

Key Challenge: Monitoring HRSA HAB Core Clinical Performance Measures to ensure patient quality of care.
HIV-related morbidity and mortality has dropped dramatically due to advances in HIV/AIDS treatment. But reductions are uneven across HIV-infected populations due to unequal access to care and variable quality of services provided. Quality management seeks to enhance the quality of HIV care provided and increase access to services. They do so by measuring how health and social services meet established professional standards and user expectations. HRSA HAB has created performance measures, which comprise indicators that providers can use in monitoring the quality of care they provide.

Major Delivery System Solution: Establish baseline data and continue to monitor HRSA HAB Performance Measures for all HIV patients regardless of payer source.

We will establish baseline data and continue to monitor core clinical performance measures data for all HIV patients to support continuous quality improvement efforts and provide patients with the safest and highest quality health care possible. This monitoring will allow us to review our performance over time and identify improvement strategies to assure that patients are receiving the highest quality care while continuing to reduce HIV-related morbidity and mortality.

The following data will be collected:

1. Baseline CD4 counts will be measured to assess the mean CD4 count and percentage of patients with CD4 counts <200 and <350. This will determine estimated percentages of patients who should be on HAART and on PCP prophylaxis.
2. Actual percentage of patients on HAART will be measured against the estimated percentages who should be on HAART.
3. Medical visits data will assess what percentage of patients still engaged in care and which percentage will need intensive case management.
4. Actual percentage of patients on PCP prophylaxis with CD4 counts<200 will be measured against the estimated percentages who should be on PCP prophylaxis.
5. HIV viral load monitoring will be measured to assess community viral load and to help case manage patients who have detectable viremia.

Note that the baseline data report does not include any data for the continuous 12 months during calendar years 2011 and 2012. Additionally, all of the measures include a milestone related to developing an improvement target during January 1, 2013 to June 30, 2013, and Table 1 in Attachment P, Supplement 1 notes that the development of a performance improvement target should occur from July 1, 2012 - December 31, 2012. This discrepancy is due to the fact that San Mateo County's Category 5 plans had not yet been approved as of December 31, 2012.

HIV Core Clinical Performance Measures (Required)				
DY 7	**DY 8, First 6 months (Jul 1, 2012-Dec 31, 2012)**	**DY 8, Second 6 months (Jan 1, 2013-Jun 30, 2013)**	**DY 9, First 6 months (Jul 1, 2013-Dec 31, 2013)**	**Related Projects (Categories I-V)**
	128. Milestone: Report six-months of baseline data for CD4 T-Cell Counts to the State. • **Metric:** Report results to the State. **129. Milestone:** Report six-months of baseline data for the HAART measure to the State. • **Metric:** Report results to the State. **130. Milestone:** Report six-months of baseline data for the Core Clinical Medical Visits measure to the State. • **Metric:** Report results to the State. **131. Milestone:** Report six-months of baseline data for PCP Prophylaxis to the State. • **Metric:** Report results to the State. **132. Milestone:** Report six-months of baseline data for the Viral Load Monitoring measure to the State.	**134. Milestone:** Report CD4 T-Cell Counts data to the State. • **Metric:** Report results to the State. **135. Milestone:** Develop a performance improvement target for CD4 T-Cell Count based on the six-month CD4 T-Cell Count data. • **Metric:** Report results to the State. **136. Milestone:** Report HAART data to the state. • **Metric:** Report results to the State. **137. Milestone:** Develop performance improvement target for HAART measure based on six-month baseline data. • **Metric:** Report results to the State. • **138. Milestone:** Report Core Clinical Medical Visits data to the state. • **Metric:** Report results to the State.	**146. Milestone:** Increase the percentage of clients with HIV infection who had 2 or more CD4 T-Cell counts performed in the measurement year [by X%] over baseline. • **Metric:** Report results to the State. **147. Milestone:** Increase the percentage of clients with HIV who are prescribed HAART [by X%] over baseline. • **Metric:** Report results to the State. **148.Milestone:** Increase the percentage of clients who had two or more medical visits in an HIV care setting in the measurement year [by X%] over baseline. • **Metric:** Report results to the State. **149.Milestone:** Increase the percentage of clients with HIV infection and a CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis [by X%] over baseline. • **Metric:** Report results to the	• Redesigning Primary Care (Cat. 2) • Spreading Primary Care Medical Homes (Cat. 2)

HIV Core Clinical Performance Measures (Required)				
DY 7	**DY 8, First 6 months (Jul 1, 2012-Dec 31, 2012)**	**DY 8, Second 6 months (Jan 1, 2013-Jun 30, 2013)**	**DY 9, First 6 months (Jul 1, 2013-Dec 31, 2013)**	**Related Projects (Categories I-V)**
	• **Metric:** Report results to the State. **133. Milestone:** Report six-months of baseline data for the Viral Load Suppression measure to the State. • **Metric:** Report results to the State.	**139. Milestone:** Develop performance improvement target for the Core Clinical Medical Visits measure based on six-month baseline data. • **Metric:** Report results to the State. **140. Milestone:** Report PCP Prophylaxis data to the state. • **Metric:** Report results to the State. **141. Milestone:** Develop performance improvement target for the PCP Prophylaxis measure based on six-month baseline data. • **Metric:** Report results to the State. **142. Milestone:** Report Viral Load Monitoring data to the state. • **Metric:** Report results to the State. **143. Milestone:** Develop performance improvement target for the Viral Load Monitoring measure based on six-month baseline data. • **Metric:** Report results to the State.	State. **150. Milestone:** Increase the percentage of patients, regardless of age, with a diagnosis of HIV with a viral load test performed at least every six months during the measurement year [by X%] over baseline. • **Metric:** Report results to the State. **151. Milestone:** Increase the percentage of patients regardless of age, with a diagnosis of HIV/AIDS with viral load below limits of quantification at last test during the measurement year [by X%] over baseline. • **Metric:** Report results to the State.	

HIV Core Clinical Performance Measures (Required)				
DY 7	**DY 8, First 6 months (Jul 1, 2012-Dec 31, 2012)**	**DY 8, Second 6 months (Jan 1, 2013-Jun 30, 2013)**	**DY 9, First 6 months (Jul 1, 2013-Dec 31, 2013)**	**Related Projects (Categories I-V)**
		144. Milestone: Report Viral Load Suppression data to the state. • **Metric:** Report results to the State. **145. Milestone:** Develop performance improvement target for the Viral Load Suppression measure based on six-month baseline data. • **Metric:** Report results to the State.		

Category 5b

Improve Clinical and Operational Outcomes for patients with HIV

Intervention #1: HIV Core Clinical Performance Measures (Optional)

Key Challenge: Monitoring HRSA HAB Core Clinical Performance Measures to ensure patient quality of care.
HIV-related morbidity and mortality has dropped dramatically due to advances in HIV/AIDS treatment. But reductions are uneven across HIV-infected populations due to unequal access to care and variable quality of services provided. Quality management seeks to enhance the quality of HIV care provided and increase access to services. They do so by measuring how health and social services meet established professional standards and user expectations. HRSA HAB has created performance measures, which comprise indicators that providers can use in monitoring the quality of care they provide.

Major Delivery System Solution: Establish baseline data, and continue to monitor, HRSA HAB Performance Measures for all HIV patients regardless of payer source.

In support of our commitment to continuous quality improvement so that patients receive the safest and highest quality health care possible, we propose to establish baseline data and continue to monitor all HIV patients core clinical performance measures data. This monitoring will allow us to assure that patients are receiving the highest quality care while continuing to reduce HIV-related morbidity and mortality. The specific additional performance measures were chosen due to an increase of approximately 30% over the previous year in the rates of syphilis, gonorrhea and Chlamydia in San Mateo County. This data will inform our clinic the percentage of patients with positive screening, who will need more intensive Harm Reduction Therapy services and Partner Services.

Note that the baseline data report does not include any data for the continuous 12 months during calendar years 2011 and 2012. Additionally, all of the measures include a milestone related to developing an improvement target during January 1, 2013 to June 30, 2013, and Table 1 in Attachment P, Supplement 1 notes that the development of a performance improvement target should occur from July 1, 2012 - December 31, 2012. This discrepancy is due to the fact that San Mateo County's Category 5 plans had not yet been approved as of December 31, 2012.

HIV Core Clinical Performance Measures (Optional)				
DY 7	**DY 8, First 6 months (Jul 1, 2012-Dec 31, 2012)**	**DY 8, Second 6 months (Jan 1, 2013-Jun 30, 2013)**	**DY 9, First 6 months (Jul 1, 2013-Dec 31, 2013)**	**Related Projects (Categories I-V)**
	152. Milestone: Report six-months of baseline data of Syphilis screening to	**156. Milestone:** Report Syphilis screening data to the State.	**164. Milestone:** Report Syphilis screening data to the State.	• Redesigning Primary Care (Cat. 2)

HIV Core Clinical Performance Measures (Optional)				
DY 7	**DY 8, First 6 months (Jul 1, 2012-Dec 31, 2012)**	**DY 8, Second 6 months (Jan 1, 2013-Jun 30, 2013)**	**DY 9, First 6 months (Jul 1, 2013-Dec 31, 2013)**	**Related Projects (Categories I-V)**
	the State. • **Metric:** Report results to the State. **153. Milestone:** Report six-months of baseline data of Chlamydia screening to the State. • **Metric:** Report results to the State. **154. Milestone:** Report six-months of baseline data of Gonorrhea screening to the State. • **Metric:** Report results to the State. **155. Milestone:** Report six-months of baseline data of Medical Case Management - Medical Visits to the State. • **Metric:** Report results to the State.	• **Metric:** Report results to the State. **157. Milestone:** Develop performance improvement target for Syphilis screening based on six-months of baseline data. • **Metric:** Report results to the State. **158. Milestone:** Report Chlamydia screening data to the State. • **Metric:** Report results to the State. **159. Milestone:** Develop performance improvement target for Chlamydia screening based on six-months of baseline data. • **Metric:** Report results to the State. **160. Milestone:** Report Gonorrhea screening data to the State. • **Metric:** Report results to the State. **161. Milestone:** Develop performance improvement target for Gonorrhea screening based on six-months of baseline data.	• **Metric:** Report results to the State. **165. Milestone:** Report Chlamydia screening data to the State. • **Metric:** Report results to the State. **166. Milestone:** Report Gonorrhea screening data to the State. • **Metric:** Report results to the State. **167. Milestone:** Report Medical Case Management - Medical Visit data to State. • **Metric:** Report results to the State.	• Spreading Primary Care Medical Homes (Cat. 2)

HIV Core Clinical Performance Measures (Optional)				
DY 7	**DY 8, First 6 months (Jul 1, 2012-Dec 31, 2012)**	**DY 8, Second 6 months (Jan 1, 2013-Jun 30, 2013)**	**DY 9, First 6 months (Jul 1, 2013-Dec 31, 2013)**	**Related Projects (Categories I-V)**
		• **Metric:** Report results to the State. **162. Milestone:** Report Medical Case Management - Medical Visits data to the State. • **Metric:** Report results to the State. **163. Milestone:** Develop performance improvement target for Medical Case Management - Medical Visits based on six-months of baseline data. • **Metric:** Report results to the State.		

DSRIP Category 5 HIV Transition Projects - Fund Allocation Table

	DY8, First 6 months	DY8, Second 6 months	DY9, First 6 months
Category 5a Projects			
Empanel Patients into Medical Homes w/HIV expertise which may include, as applicable, Ryan White and non-Ryan White providers	$84,359.83	$84,359.83	$84,359.83
Enhance data sharing between SMMC & the San Mateo County Division of Public Health	$84,359.83	$84,359.83	$84,359.83
Ensure access to Ryan White wrap-around services for new LIHP enrollees	$84,359.84	$84,359.84	$84,359.84
Category 5b Projects			
CD4 T-Cells (defined as of July 2008)	$25,307.95	$ 25,307.95	$ 25,307.95
HAART (defined as of July 2008)	$25,307.95	$ 25,307.95	$ 25,307.95
Core Clinical Medical Visits (defined as of July 2008)	$25,307.95	$ 25,307.95	$ 25,307.95
PCP Prophylaxis (defined as of July 2008)	$25,307.95	$ 25,307.95	$ 25,307.95
Viral Load Monitoring (defined as of November 2011)	$25,307.95	$ 25,307.95	$ 25,307.95
Viral Load Suppression (defined as of November 2011)	$25,307.95	$ 25,307.95	$ 25,307.95
Syphilis Screening	$25,307.95	$ 25,307.95	$ 25,307.95
Chlamydia Screening	$25,307.95	$ 25,307.95	$ 25,307.95
Gonorrhea Screening	$25,307.95	$ 25,307.95	$ 25,307.95
Medical Case Management/Medical Visits	$25,307.95	$ 25,307.95	$ 25,307.95
TOTAL	$506,159.00	$506,159.00	$506,159.00

Appendix A: The Innovative Care Clinic (ICC) – A Successful Implementation of the Medical Home Model at SMMC

THE VISION

The ICC's vision is to use a team-based approach to strive for high quality care that addresses the whole person's need with emphasis on self empowerment, education and prevention. To do this, they use the following strategies:

- Team-Based Care
- Case management and telephone outreach
- Flexible/Expanded Staff roles
- Chronic Disease Management
- Medication Management Program
- Advanced Access
- Outcomes Focused
- Utilization of Registry/EMR
- Focus on Health Promotion/Education

Although the ICC "go live" is built from years of experience with chronic disease management, over the last three years there has been an intensive focus on clinic redesign including the following specific changes:

- Staff formation into teams/pods
- Utilization of registry for all providers
- Utilization of a special camera to screen for diabetic retinopathy, Increased use of group visits
- Clinic physical space redesign to support team-based care
- Participation in the RAND/MacColl study and Optimizing Primary Care Collaborative

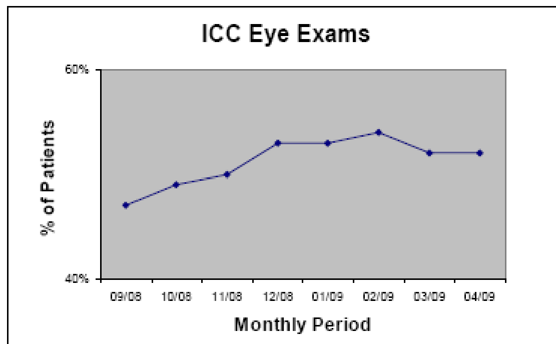
Chronic Disease Management	
HbA1c (%<7.0)	60%
LDL (%<100)	70%
Pneumovax	**80%**
Flu Vaccine	80%
Eye Exams	**80%**
Foot Exams	**80%**
Self Management Goals	**80%**
ASA	**80%**
BP (%<130/80)	60%
Health care Maintenance	
Mammograms	
Advanced Access	
Panel Size	
Provider Supply	
Provider Demand	
Activity	
No Show Rate	
3rd Next Appt	
Continuity	
Patient Satisfaction	
Cycle Time	
Patient Survey	
Staff Survey	
Finance	
MD/RN Productivity	
Total Visits to ICC	
ER Visits	
Hospitalizations	

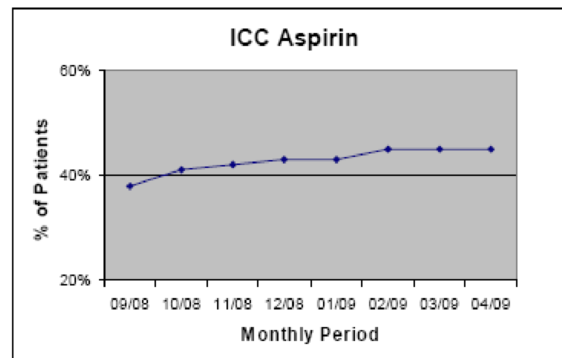
TRACKING OUTCOMES

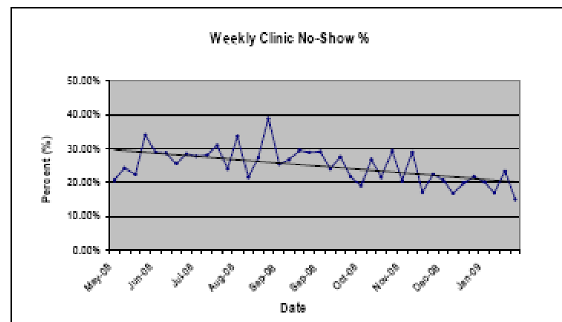
Through its participation and experience in multiple collaboratives and research efforts, the ICC leadership and team developed the core process and outcome measures shown to the right.

RESULTS

Within the first 2 years all of the ICC providers began using the CDEMS registry to track diabetic patients. After one year, the patients in the registry totaled 1435. For these patients, they have been tracking many of these dashboard measures over time. For example:







Appendix B: Four Quadrant Physical/Behavioral Clinical Integration Model

Behavioral Health Risk/Status (Low → High)		
High	**Quadrant II** **BH ↑ PH ↓** • Behavioral Health **(BH)** Case Manager w/ responsibility for coordination w/Primary Care Provider **(PCP)** • PCP (with standard screening tools and BH practice guidelines)	**Quadrant IV** **BH ↑ PH ↑** • PCP (with standard screening tools and BH practice guidelines) • BH Case Manager w/ responsibility for coordination w/ PCP
Low	**Quadrant I** **BH ↓ PH ↓** • PCP (with standard screening tools and BH practice guidelines) • PCP-based BH	**Quadrant III** **BH ↓ PH ↑** • PCP (with standard screening tools and BH practice guidelines) • PCP-based BH (or in specific specialties)* • SNF/home based care • Other community supports

Low ← **Physical Health Risk/Status** → High

Appendix B: National and State Reporting of SSIs Following Targeted Surgical Procedures

National: CMS has been measuring surgical care processes using the Surgical Care Improvement Project measures since 2006. In 2008, the Department of Health and Human Services established a senior-level Steering Committee for the Prevention of Healthcare –Associated Infections (HAIs), providing a roadmap for HAI prevention in acute care hospitals, focusing on those infections where the associated morbidity and mortality was most severe, and where scientific information on prevention and the capacity to measure improvements was most complete. An Action Plan was established with six priority areas, including SSI. Additionally, the House Committee on Appropriations asked in a 2009 Report that CMS include a SSI rate in its "pay for reporting" system that had been developed by the Hospital Quality Alliance.

As a result, CMS adopted a SSI measure for the Hospital Inpatient Quality Reporting program as part of the federal FY 2014 measure set, and data submission on the measure will begin with January 2012 events. This measure will include SSIs following these procedures: coronary artery bypass graft surgery, certain orthopedic procedures, and bariatric surgery for obesity.[7] Additionally as part of the federal government's aligned policy, both Medicare and Medicaid will no longer pay for SSIs resulting from those procedures.

State: On February 17, 2011, the Healthcare Associated Infections Advisory Committee to the California Department of Public Health presented a priority list of surgical procedures based on (1) volume; (2) risk of infection; (3) consequences of infection; and (3) suitability for public reporting. These prioritized procedures were all drawn from the NHSN operative procedures list, and the top procedures include: hip prosthesis, coronary artery bypass graft surgery, colon surgery, cardiac surgery, and knee prosthesis[8]. Beyond this guidance, there remains a lack of clarity at the state level on which procedures will be reported statewide for SSI. [9]

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[7] Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2012 Rates, CMS-1518, Hospital Inpatient Quality Reporting (IQR) Program.

[8] California HAI Advisory Committee, SB 1058 SSI Reporting Requirements Discussion, February 8, 2011, http://www.cdph.ca.gov/services/boards/Documents/SSIsandOperativeProceduresSSI%202-8-11.pdf; SSI procedures listed in order of priority

[9] There have been two conflicting state regulations issued on public reporting of SSIs in March and April of 2011, as well as litigation contesting the regulations. As a result, there remains a lack of consensus on SSI reporting in California at this time.