KERN MEDICAL CENTER

AFFILIATED WITH UNIVERSITY OF CALIFORNIA SCHOOLS
OF MEDICINE AT LOS ANGELES AND IRVINE

April 15, 2011

Department of Health Care Services
Medi-Cal Benefits, Waiver Analysis and Rates Division
1501 Capitol Avenue, MS 4600
Sacramento, CA 95899-7417

Attention: Neal Kohatsu, Vickie Orlich, Jennifer Kent, and Michelle Colyer

RE: Delivery System Reform Incentive Payment (DSRIP) - Category 3: Population-Focused Improvement Reporting Measures

Dear Medi-Cal Benefits, Waiver Analysis and Rates Division:

As Chief Executive Officer of Kern Medical Center (KMC), I am submitting the attached addendum 'Category 3: Population-Focused Improvement Reporting Measures' to the Delivery System Reform Incentive Payment (DSRIP) Five Year Implementation Plan submitted on Friday, February 18, 2011.

We look forward to working with you to improve access, quality of care, and the overall patient experience for Kern County's underserved and ethnically diverse patients.

If you have any questions, I can be reached at (661) 326-2102.

Sincerely,

Paul J. Hensler, FACHE
Chief Executive Officer

PJH:hc
Attachment

KERN MEDICAL CENTER
ADDENDUM TO DSRIP FIVE-YEAR PLAN SUBMITTED FEBRUARY 18, 2011
CATEGORY 3: POPULATION-FOCUSED IMPROVEMENT REPORTING MEASURES
APRIL 15, 2011

Category 3:

Per the California Section 1115 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.

Goal: The goal of the projects in category 3 is to measure and report on population health measures in order to understand the health status of key populations and build a robust capacity for reporting on population health.

Being able to report on population-level health measures is the first step to developing and fine-tuning interventions to improve quality. Creating a plan to report on these measures is especially timely, since KMC will soon be rolling out an electronic health record which will greatly enhance KMC's reporting ability. The measures on which KMC will be reporting fall within the following categories: patient/caregiver experience, care coordination, preventive health, and at-risk populations.

Patient/Caregiver Experience

KMC operates four primary care and several specialty clinics, which include medicine specialties, orthopedics, eye, surgery and surgery specialties, and OB-GYN clinics. Together, these clinics experience over 400 encounters daily. Currently, KMC does not measure patient satisfaction or the patient experience in the outpatient setting. A positive patient/caregiver experience is essential, especially in the outpatient setting, for its ability to impact both quality and cost of care. Research indicates that increased satisfaction and improved communication between providers and patients has been shown to increase compliance with treatment plans, especially among patients with chronic diseases.[1] The interventions that KMC proposed as category 1 and 2 projects, such as expanding primary care capacity, enhancing urgent medical advice, increasing specialty care capacity, enhancing culturally competent care, expanding the medical home, redesigning primary care, and implementing a patient care navigation program all aim to improve the patient/caregiver experience.

KMC will be measuring patient experience among patients visiting its ambulatory clinics through implementing the CG CAHPS surveys in its four primary care and five specialty clinic areas.

Care Coordination and At-Risk Populations

Hospitalization rates due to congestive heart failure (CHF) and Diabetes in Kern County are among the highest compared to other counties in the area. As of 2008, Kern County had 47.3 hospitalizations per 10,000 residents for CHF and 28.4 diabetes-related hospitalizations per 10,000 residents[2]. Asthma is also a serious concern in Kern County. Although the percentage of children with asthma is equivalent to

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[1] Nagay VT, Wolfe GR. Cognitive predictors of compliance in chronic disease patients. Med Care. 1984; 10: 912-921.
[2] Source: 2008 OSHPD. Information accessed through healthykern.org

the state average, Kern County experiences a higher hospitalization rate among children with asthma than other California counties. These data support the need for interventions focused on these at-risk populations.

Through improved coordination of care and an increased focus on disease management in the medical home, patients' chronic conditions will be better controlled, resulting in fewer hospitalizations. The interventions that KMC has proposed in categories 1 and 2, such as implementation of medical homes, use of disease registries, care navigation for frequent users, and increased access to primary and specialty care will result in better management of chronic diseases. By being able to report on measures related to these conditions such as rates of admission and control of high blood pressure and hemoglobin A1C, KMC can measure the success of its interventions.

KMC will be collecting data for these measures from a combination of reports from its electronic health record, disease registry and practice management system.

Preventive Health

In addition to improving care for patients with chronic conditions, KMC will be implementing programs that transform its primary care clinics into medical homes that pro-actively manage patients' health. KMC spent over $4,000,000 in 2008 on admissions of uninsured patients admitted for ambulatory care sensitive conditions. The prevalence of these conditions indicates a need for improved preventive care and timely, ongoing treatment. Interventions include the implementation of reminder systems for preventive screenings as well as pro-actively reaching out to newly assigned patients in a timely manner for a primary care appointment. KMC will be reporting several preventive health measures, including mammography screening rates, influenza immunization rates, child weight screening rates, BMI among children, and rates of smokers receiving tobacco cessation education. These measures will serve as indicators for patients' ability to receive vital preventive health care in the primary care setting.

KMC will be collecting data for these measures from its practice management system as well as its electronic health record.

Expected outcome: To report on measures relating to the patient/caregiver experience, care coordination, preventive health, and at-risk populations

Patient/Care Giver Experience				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
	1. Undertake the planning, redesign, translation, training and contract negotiations with vendors in order to implement CG-CAHPS in DY8.	1. Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme for at least data from the last two quarters of the demonstration year to the State 2. Report results of CG CAHPS questions for "How Well Doctors Communicate With Patients" theme for at least data from the last two quarters of the demonstration year to the State 3. Report results of CG CAHPS questions for "Helpful, Courteous, and Respectful Office Staff" theme for at least data from the last two quarters of the demonstration year to the State 4. Report results of CG CAHPS questions for "Patients' Rating of the Doctor" theme for at least data from the last two quarters of the demonstration year to the State 5. Report results of CG CAHPS questions for "Shared Decisionmaking" theme for at least data from the last two quarters of the demonstration year to the State	6. Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme to the State 7. Report results of CG CAHPS questions for "How Well Doctors Communicate With Patients" theme to the State 8. Report results of CG CAHPS questions for "Helpful, Courteous, and Respectful Office Staff" theme to the State 9. Report results of CG CAHPS questions for "Patients' Rating of the Doctor" theme to the State 10. Report results of CG CAHPS questions for "Shared Decisionmaking" theme to the State	11. Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme to the State 12. Report results of CG CAHPS questions for "How Well Doctors Communicate With Patients" theme to the State 13. Report results of CG CAHPS questions for "Helpful, Courteous, and Respectful Office Staff" theme to the State 14. Report results of CG CAHPS questions for "Patients' Rating of the Doctor" theme to the State 15. Report results of CG CAHPS questions for "Shared Decisionmaking" theme to the State

Care Coordination				
Year 1	Year 2	Year 3	Year 4	Year 5
	1. Report results of the Diabetes, short-term complications measure to the State 2. Report results of the Uncontrolled Diabetes measure to the State	3. Report results of the Diabetes, short-term complications measure to the State 4. Report results of the Uncontrolled Diabetes measure to the State 5. Report results of the Congestive Heart Failure measure to the State 6. Report results of the Chronic Obstructive Pulmonary Disease measure to the State	7. Report results of the Diabetes, short-term complications measure to the State 8. Report results of the Uncontrolled Diabetes measure to the State 9. Report results of the Congestive Heart Failure measure to the State 10. Report results of the Chronic Obstructive Pulmonary Disease measure to the State	11. Report results of the Diabetes, short-term complications measure to the State 12. Report results of the Uncontrolled Diabetes measure to the State 13. Report results of the Congestive Heart Failure measure to the State 14. 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. Sagebrush Pediatric Clinic
2. Sagebrush Family Medicine Clinic
3. Sagebrush Internal Medicine Clinic
4. KMC Internal Medicine 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]

Preventive Health				
Year 1	Year 2	Year 3	Year 4	Year 5
	1. Report results of the Mammography Screening for Breast Cancer measure to the State 2. Reports results of the Influenza Immunization measure to the State	3. Report results of the Mammography Screening for Breast Cancer measure to the State 4. Reports results of the Influenza Immunization measure to the State 5. Report results of the Child Weight Screening measure to the State 6. Report results of the Pediatrics Body Mass Index (BMI) measure to the State 7. Report results of the Tobacco Cessation measure to the State	8. Report results of the Mammography Screening for Breast Cancer measure to the State 9. Reports results of the Influenza Immunization measure to the State 10. Report results of the Child Weight Screening measure to the State 11. Report results of the Pediatrics Body Mass Index (BMI) measure to the State 12. Report results of the Tobacco Cessation measure to the State	13. Report results of the Mammography Screening for Breast Cancer measure to the State 14. Reports results of the Influenza Immunization measure to the State 15. Report results of the Child Weight Screening measure to the State 16. Report results of the Pediatrics Body Mass Index (BMI) measure to the State 17. Report results of the Tobacco Cessation measure to the State

Preventive Health Denominator:

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

1. Sagebrush Pediatric Clinic
2. Sagebrush Family Medicine Clinic
3. Sagebrush Internal Medicine Clinic
4. KMC Internal Medicine 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).[1]

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

At-Risk Populations Denominator:

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

1. Sagebrush Pediatric Clinic
2. Sagebrush Family Medicine Clinic
3. Sagebrush Internal Medicine Clinic
4. KMC Internal Medicine 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 3 Five-Year Incentive Payment Table

	DY 6	DY 7	DY 8	DY 9	DY 10
Category 3					
Patient/Care Giver Experience	-	$ 2,413,125	$ 3,217,500	$ 4,826,250	$ 5,630,625
Care Coordination	-	$ 2,413,125	$ 3,217,500	$ 4,826,250	$ 5,630,625
Preventive Health	-	$ 2,413,125	$ 3,217,500	$ 4,826,250	$ 5,630,625
At-Risk Populations	-	$ 2,413,125	$ 3,217,500	$ 4,826,250	$ 5,630,625

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

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