RIVERSIDE COUNTY
REGIONAL MEDICAL CENTER

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

CATEGORY 3:
POPULATION-FOCUSED IMPROVEMENT
REPORTING MEASURES

APRIL 18, 2011

CATEGORY 3: POPULATION-FOCUSED IMPROVEMENT

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." The Category 3 measures are: 1) aligned with the low-income, Medicaid, and uninsured population in question; 2) identified as high priority, given the health care needs and issues of the patient population served by designated public hospital systems (DPH); and 3) viewed as valid health care indicators to inform and fuel improvements in population health within the health care safety net.

Category 3 data measures include the following domains:

- Patient/Caregiver Experience
- Care Coordination
- Preventive Health
- At-Risk Populations

Patient Safety is being addressed in Category 4 of RCRMC's DSRIP plan.

Related Projects:

The Category 3 milestones are supported by initiatives included in other sections of RCRMC's DSRIP Plan:

- Through the implementation of medical homes, patients will receive care in a more coordinated rather than episodic manner. They will be able to establish an ongoing relationship with their medical home provider team who will manage all of their care. As a result, patients should receive the right care at the right time at the right place, including ongoing preventive care.
  (Category 2: Expand Medical Homes)

- Many of the health status measures to be tracked in Category 3 pertain to chronic diseases, including diabetes. RCRMC will be implementing a comprehensive set of diabetes management initiatives that encompasses the continuum of hospital services – from inpatient care to perioperative care to outpatient care. Clinicians will use a diabetes registry to track the care provided to ensure patients receive screenings, lab tests, and other exams at the proper intervals. These initiatives should assist in improving patient clinical outcomes, including lower blood glucose and cholesterol levels.
  (Category 2: Expand Chronic Care Management Models; Category 1: Implement and Utilize Disease Management Registry Functionality)

- One of the Category 3 measures for the at-risk population includes the 30-day Congestive Heart Failure (CHF) readmission rate. RCRMC's plan to establish a CHF Clinic will standardize treatment processes and provide continuity of care between inpatient and outpatient services. This initiative should assist in decreasing the CHF readmission rate.
  (Category 1: Expand Specialty Care Capacity)

- The patient/caregiver experience pilot programs targeted for the Family Care Clinic and other clinics are designed to create an environment which is more patient-centered. Patient satisfaction data measures in Category 3 will assist the Patient/Caregiver Experience Steering Committee in tracking the impact of proactive changes being made to enhance the patient/caregiver's clinic experience.
  (*Category 2: Redesign to Improve Patient Experience)*

Patient/Caregiver 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 Year 3 (DY 8).	2. Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme for at least data from the last two quarters of the demonstration year to the State. 3. Report results of CG CAHPS questions for "How Well Doctors Communicate with Patients" theme for at least data from the last two quarters of the demonstration year to the State. 4. Report results of CG CAHPS questions for "Helpful, Courteous, and Respectful Office Staff" theme for at	7. Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme to the State. 8. Report results of CG CAHPS questions for "How Well Doctors Communicate with Patients" theme to the State. 9. Report results of CG CAHPS questions for "Helpful, Courteous, and Respectful Office Staff" theme to the State. 10. Report results of CG CAHPS questions for "Patients' Rating of	12. Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme to the State. 13. Report results of CG CAHPS questions for "How Well Doctors Communicate with Patients" theme to the State. 14. Report results of CG CAHPS questions for "Helpful, Courteous, and Respectful Office Staff" theme to the State. 15. Report results of CG CAHPS questions for "Patients' Rating of

Patient/Caregiver Experience				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
		least data from the last two quarters of the demonstration year to the State. 5. Report results of CG CAHPS questions for "Patients' Rating of the Doctor" theme for at least data from the last two quarters of the demonstration year to the State. 6. Report results of CG CAHPS questions for "Shared Decision Making" theme for at least data from the last two quarters of the demonstration year to the State.	the Doctor" theme to the State. 11. Report results of CG CAHPS questions for "Shared Decision Making" theme to the State.	the Doctor" theme to the State. 16. Report results of CG CAHPS questions for "Shared Decision Making" 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 RCRMC's primary care clinics:

1. Family Care Clinic
2. Internal Medicine Clinic
3. Women's Health Clinic
4. Pediatrics 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.	3. Report results of the Mammography Screening for Breast Cancer measure to the State.	8. Report results of the Mammography Screening for Breast Cancer measure to the State.	13. Report results of the Mammography Screening for Breast Cancer measure to the State.
	2. Report results of the Influenza Immunization measure to the State.	4. Report results of the Influenza Immunization measure to the State.	9. Report results of the Influenza Immunization measure to the State.	14. Report results of the Influenza Immunization measure to the State.
		5. Report results of the Child Weight Screening measure to the State.	10. Report results of the Child Weight Screening measure to the State.	15. 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.	11. Report results of the Pediatrics Body Mass Index (BMI) measure to the State.	16. Report results of the Pediatrics Body Mass Index (BMI) to the State.
		7. Report results of the Tobacco Cessation measure to the State.	12. Report results of the Tobacco Cessation measure to the State.	17. Report results of the Tobacco Cessation measure to the State.

Preventive Health Denominator:

The following are RCRMC's primary care clinics:

1. Family Care Clinic
2. Internal Medicine Clinic
3. Women's Health Clinic
4. Pediatrics 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]

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 (<100mg/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 (<100mg/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	10. Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100mg/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	17. Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100mg/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.

At-Risk Populations				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
		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.	the State. 16. Report results of the Diabetes Composite 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 RCRMC's primary care clinics:

1. Family Care Clinic
2. Internal Medicine Clinic
3. Women's Health Clinic
4. Pediatrics 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 determined as the prior demonstration year (July 1 – June 30 of the prior year).[i]

Category 3: Five-Year Incentive Payment Table

	Year 1/DY 6	Year 2/DY 7	Year 3/DY 8	Year 4/DY 9	Year 5/DY 10
Category 3					
Patient/Caregiver Experience	-	$4,182,750	$5,577,000	$8,365,500	$9,759,750
Care Coordination	-	$4,182,750	$5,577,000	$8,365,500	$9,759,750
Preventive Health	-	$4,182,750	$5,577,000	$8,365,500	$9,759,750
At-Risk Populations	-	$4,182,750	$5,577,000	$8,365,500	$9,759,750

[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 two 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.