SAN MATEO MEDICAL CENTER

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

CATEGORY 3: POPULATION-FOCUSED IMPROVEMENT REPORTING MEASURES

APRIL 15, 2011

Narrative:

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.

Patient/Care Giver Experience				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
	1. **Undertake the necessary planning, redesign, translation, training and contract negotiations in order to implement CG-CAHPS in DY8.**	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 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 Decisionmaking" theme for at least data from the last two quarters of the demonstration year to the State**	7. **Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme to the State** 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 the Doctor" theme to the State** 11. **Report results of CG CAHPS questions for "Shared Decisionmaking" theme to the State**	12. **Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme to the State** 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 the Doctor" theme to the State** 16. **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. *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]

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. *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]

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. *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 3 Five-Year Incentive Payment Table

	DY 6	DY 7	DY 8	DY 9	DY 10
Category 3					
Patient/Care Giver Experience	-	$1,394,250	$1,859,000	$2,788,500	$3,253,250
Care Coordination	-	$1,394,250	$1,859,000	$2,788,500	$3,253,250
Preventive Health	-	$1,394,250	$1,859,000	$2,788,500	$3,253,250
At-Risk Populations	-	$1,394,250	$1,859,000	$2,788,500	$3,253,250

[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.