SAN MATEO COUNTY
HEALTH SYSTEM

TO: Nadereh Pourat, PhD, Associate Professor
UCLA School of Public Health

FROM: Susan P. Ehrlich, MD, MPP, Interim CEO
San Mateo Medical Center

RE: Additional Data submission

DATE : June 4, 2009

Thank you for the opportunity to submit additional data regarding our CI project in San Mateo County. With this information, we hope to provide you with a more complete description of the impact the Coverage Initiative funding has had on ambulatory care innovation in San Mateo County.

The goals of our CI program, known as the Access and Coverage for Everyone Program (ACE), were to:

- Expand coverage to the uninsured
- Strengthen our system of care for the uninsured and underinsured by utilizing a third party administrator, our local COHS
- Improve the quality and efficiency of our ambulatory system of care by implementing a clinic that would encompass all aspects of "radically redesigned" ambulatory care to address chronic disease management and improved patient experience.

The centerpiece of innovation in our ambulatory system is our Innovative Care Clinic. This clinic builds on 5 years of experience in developing chronic disease management for adults. The ICC, formerly the Main Campus Adult Primary Care Clinic, "went live" in February, 2009. With this clinic, we have sought to embody all aspects of innovative primary care and chronic disease management. The clinic provides 17,000 visits through 6 FTE (12 providers) annually.

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 mgt, telephone outreach, home-health
- 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 nine months 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
- Utilizing the CDEMS registry sheet as a progress note
- Clinic physical space redesign to support team-based care
- Participation in the RAND/MacColl study and Optimizing Primary Care Collaborative

TRACKING OUTCOMES

Through it's participation and experience in multiple collaboratives and research efforts, the ICC leadership and team developed the following core process and outcome measures:

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	

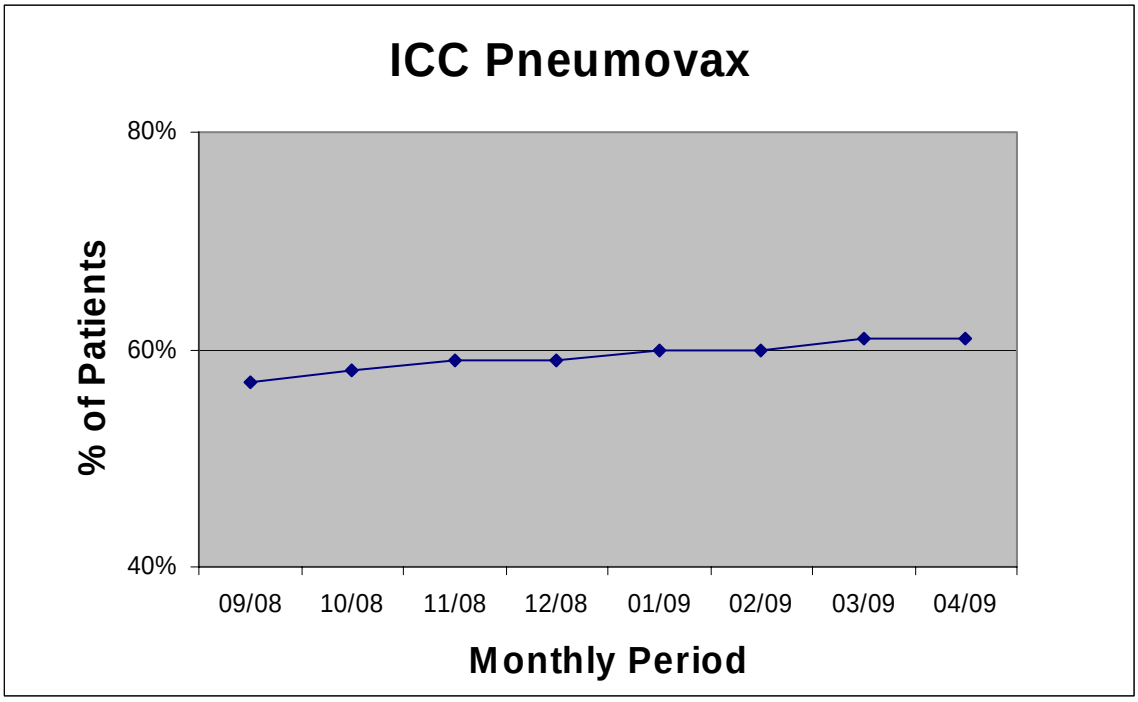
Activity
No Show Rate
3rd Next Appt
Continuity

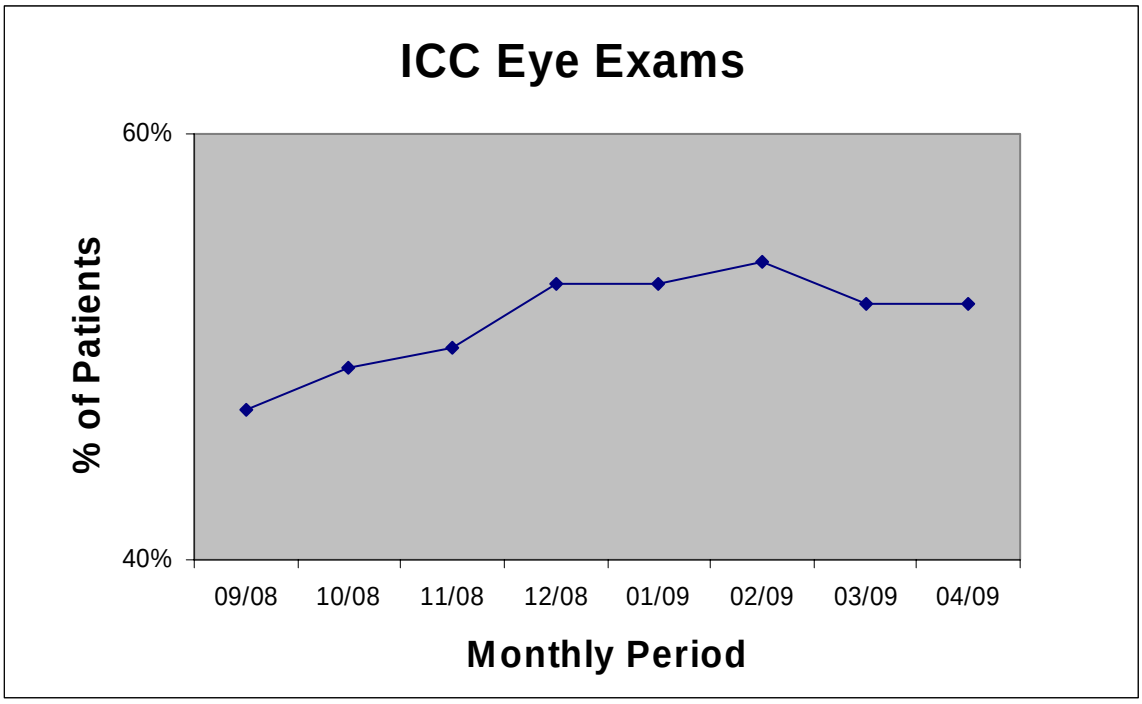
Patient Satisfaction
Cycle Time
Patient Survey
Staff Survey

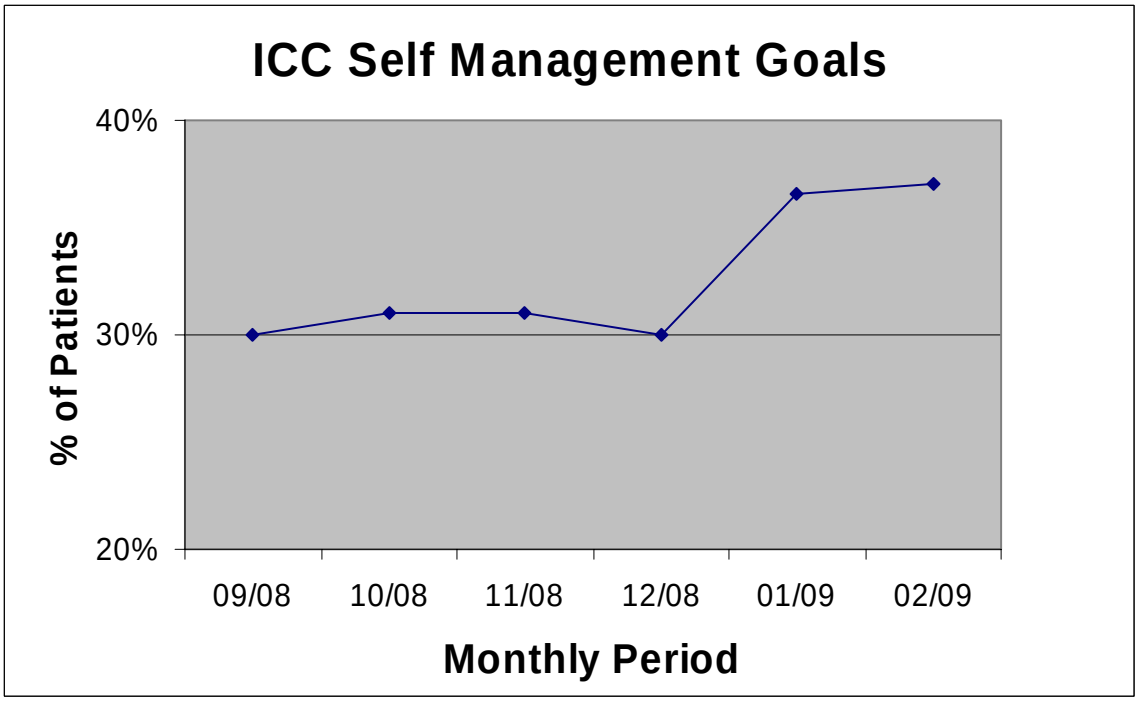
Finance
MD/RN Productivity
Total Visits to ICC
ER Visits
Hospitalizations

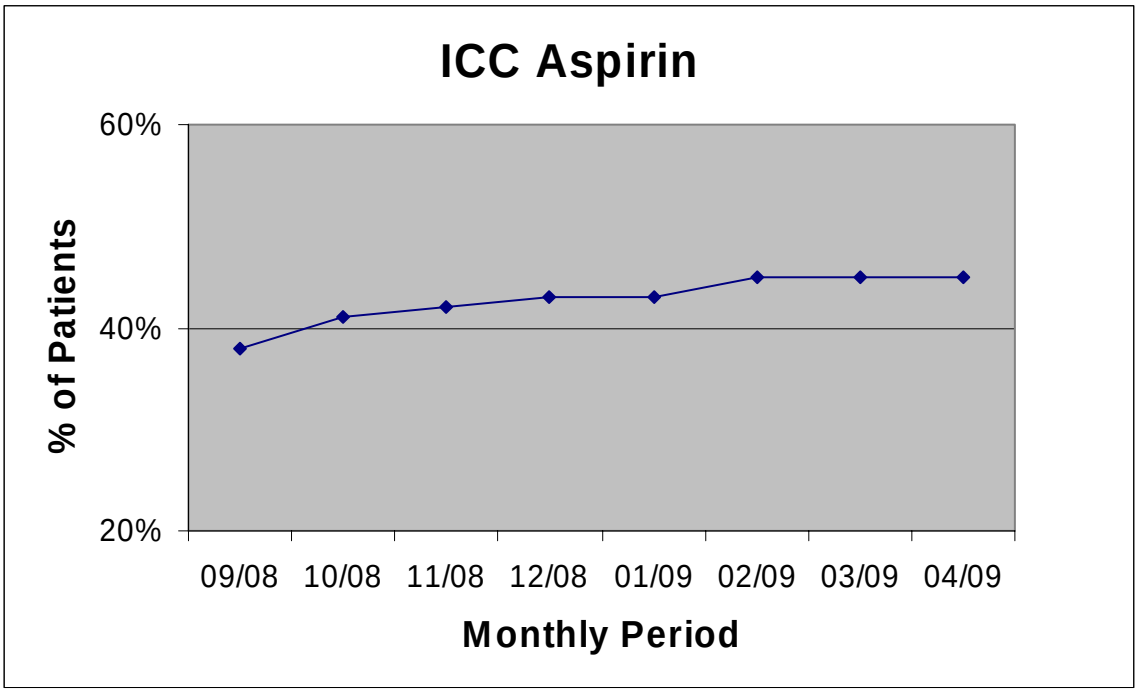
RESULTS

Within the last year all of the ICC providers have begun using the CDEMS registry to track diabetic patients. Currently patients in the registry total 1435. For these patients, they have been tracking many of these dashboard measures over time. For example:




ICC Eye Exams
60%
40%
% of Patients
09/08
10/08
11/08
12/08
01/09
02/09
03/09
04/09
Monthly Period


ICC Self Management Goals
40%
30%
20%
% of Patients
09/08
10/08
11/08
12/08
01/09
02/09
Monthly Period


ICC Aspirin
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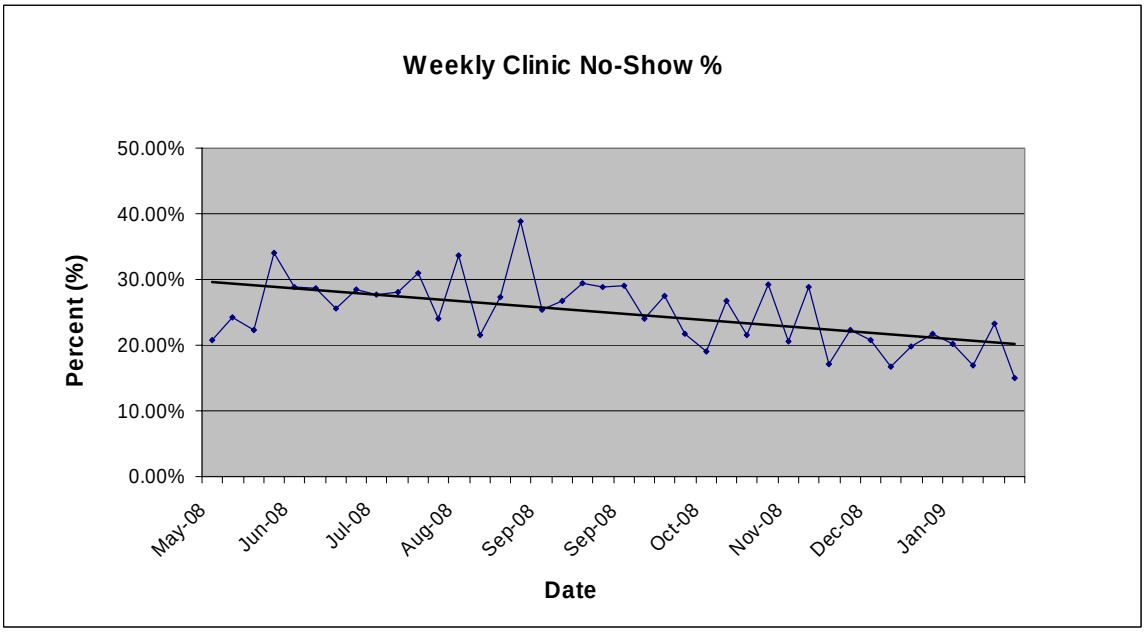
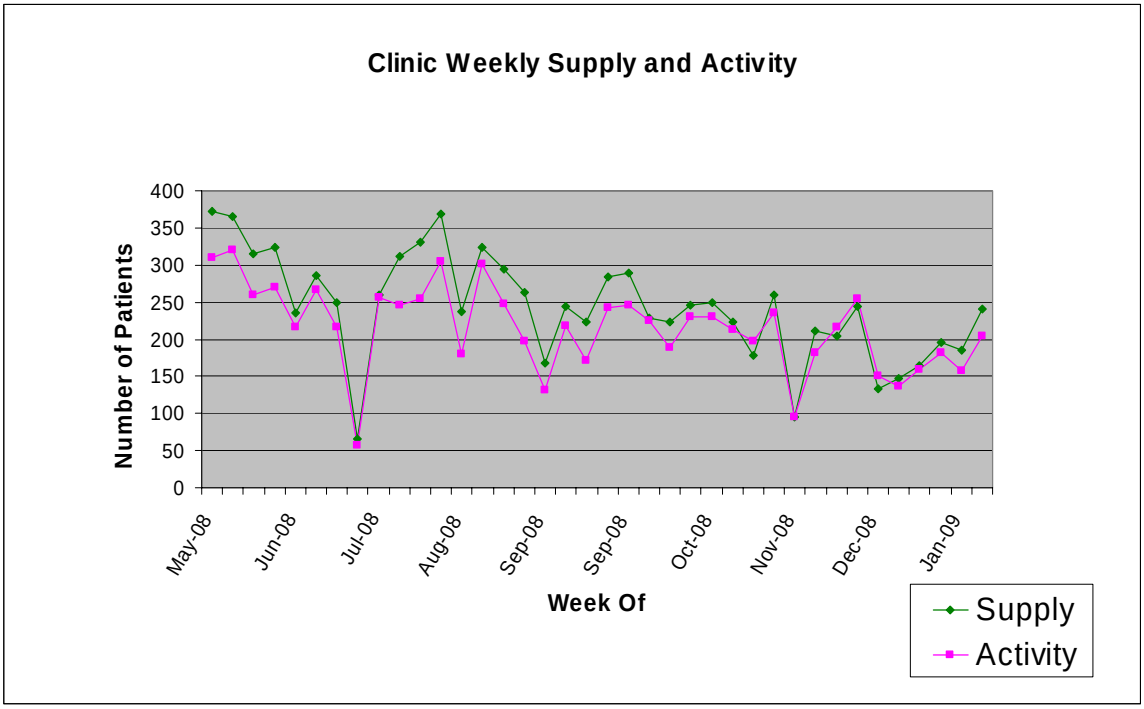
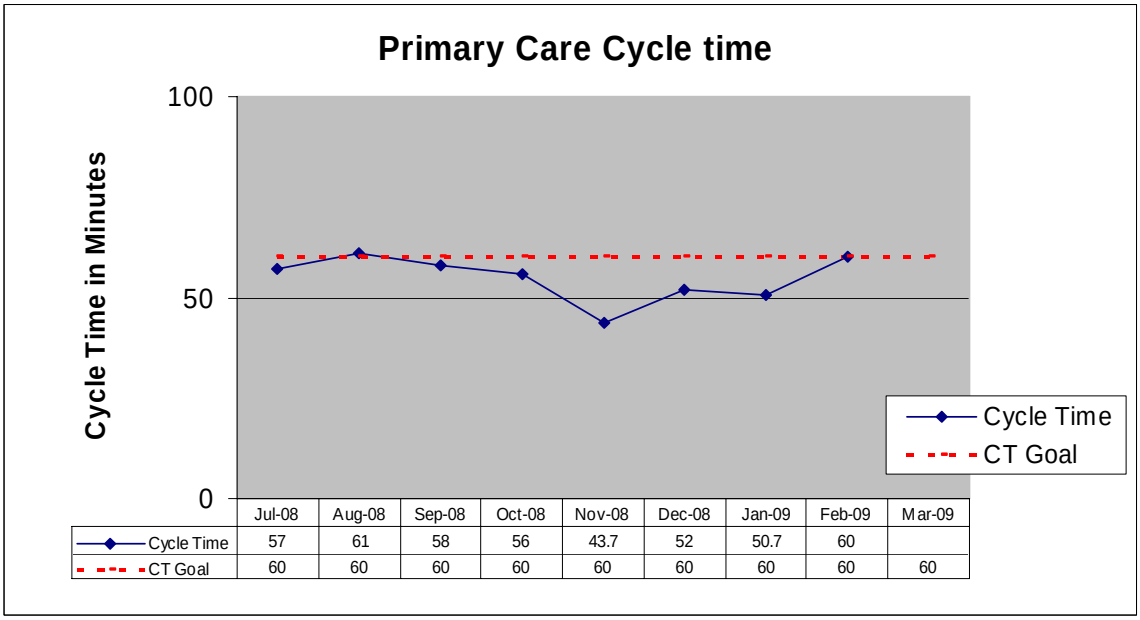
Monthly Period


Weekly Clinic No-Show %
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Percent (%)
May-08
Jun-08
Jul-08
Aug-08
Sep-08
Sep-08
Oct-08
Nov-08
Dec-08
Jan-09
Date





	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Cycle Time	57	61	58	56	43.7	52	50.7	60	
CT Goal	60	60	60	60	60	60	60	60	60

HOW DID THE ICC MAKE GAINS?

The ICC primarily attributes its gains to:

- Monthly measuring and tracking of data,
- Reviewing numbers with providers,
- Implementing processes targeted to improve the goal (for example, the medical assistant is instructed to ask for self management goals, to have patients remove shoes, and to do registry outreach for vaccination).

MORE PROGRESS TO COME

One month ago, the ICC was the first SMMC clinic to go live with our new Ambulatory Electronic Medical Record. This has been a tremendous undertaking, but implementation has met all milestones. Over the next three to six months, the ICC will:

- Have data on all dashboard measures
- Make further gains towards our goals for all dashboard measures
- Regain productivity losses from AEMR implementation
- Implement tests of change in order to improve performance on benchmark measures
- Phase out use of the CDEMS registry and migrate to use of the AEMR registry